The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

HEALTHY FAMILIES PROGRAM
Health Plan Model Contract and Proposal Solicitation
July 1, 2005 - June 30, 2008

This notice provides important information regarding the selection of new and continuing health plan contractors for the purpose of providing comprehensive health care to subscribers in the Healthy Families Program (HFP) for the period July 1, 2005 through June 30, 2008. **A supplemental solicitation for participation in the Rural Health Demonstration Project from July 1, 2005 through June 30, 2007 is also included as Enclosure 9.**

Background

The Managed Risk Medical Insurance Board (MRMIB) administers the HFP. In this solicitation, MRMIB is seeking proposals from health plans currently participating in HFP as well as new health plans interested in partnering with MRMIB to provide health services to the program's subscribers.

Since July 1, 1998, the Healthy Families Program has offered low-cost comprehensive health, dental and vision coverage to uninsured children with family incomes above the no-cost Medi-Cal eligibility level but not exceeding 250% of the federal poverty level (FPL), with limited exceptions. As of August 31, 2004, 681,992 children were enrolled in the program. The program is funded with a combination of federal State Children's Health Insurance Program funds and state funds.

Coverage is provided through a purchasing pool in which families select a health, dental and vision plan from several offered in their area of residence. In the 2004-05 contract year, a total of 27 health plan products, five dental plan products, and one vision plan are available through HFP in various part of California.

Except for American Indian and Alaskan Native subscribers, families contribute toward the cost of HFP coverage in the form of premiums and copayments. Families currently pay premiums ranging from $4 to $9 per child per month, up to a family maximum of $27 per month. Effective July 1, 2005, families with incomes between 200% and 250% of the FPL will pay $12 to $15 per child per month, up to a family maximum of $45 per month. Families that select a health plan designated as a Community Provider Plan (CPP) receive a $3 discount per child on their monthly premiums. (CPP is explained in more detail under Health Plan Provider Networks below.)

Covered services and benefits are described in HFP regulations (Title 10 California Code of Regulations, Chapter 5.8, Article 3, in sections 2699.6700 through 2699.6707), and referenced in Item IV, Covered Services and Benefits, in Exhibit A, Scope of Services of the model contract. Program regulations, as well as other HFP information, are available on the MRMIB website (www.mrmib.ca.gov). If a subscriber has been authorized by the California Children's Services (CCS) Program to receive services, medically necessary services to treat CCS-eligible conditions are "carved out" of HFP benefits. Similarly, services provided by a county to children with serious emotional disturbance (SED) or serious mental disorder are "carved out" of HFP benefits.

Eligible Entities

Entities eligible to respond to this solicitation are those health plans that have obtained or will obtain regulatory authority to offer the HFP benefit package as a licensed health care service plan (California Department of Managed Health Care (DMHC)) or insurer (California Department of Insurance (DOI)). Interested entities are encouraged to contact DMHC or DOI as soon as possible to clarify if additional regulatory review and approval are needed.

All entities seeking to provide health services to HFP subscribers should be familiar with Title XXI of the federal Social Security Act, the authorizing state statute (Insurance Code section 12693 et seq.), and HFP regulations.

Health Plan Provider Networks

MRMIB is seeking to provide program subscribers with broad-based access to providers. As such, the Board is requiring plans to submit their entire licensed service area and is asking health plans to provide subscribers with access to the plans' largest commercial (or for plans that currently serve only Medi-Cal members, their full Medi-Cal) provider networks. Health plans that participate in both the Medi-Cal and the commercial health insurance markets are being asked to provide HFP subscribers with access to their commercial network and are encouraged to enhance their commercial networks with those providers and facilities that are currently available only in the Medi-Cal network.

In the Health Plan Fact Sheet, health plans are required to submit their pediatric and adolescent enrollment capacity by county. Final determination of network adequacy will be the responsibility of each health plan's licensing entity. Health plans are strongly cautioned against proposing use of a "scaled back" or "limited" provider network. It is the Board's experience that the use of a scaled back/limited network will lead to confusion among both subscribers and providers.

The program's authorizing legislation permits the Board to offer a subscriber premium discount to the health plan in each area that has done the best job of including traditional and safety net providers in its network. The plan designated to receive the premium discount is known as the Community Provider Plan (CPP). The CPP

designation methodology is specified in the HFP regulations (see Article 4, section 2699.6805). Annually, the Board releases the traditional and safety net provider lists (CHDP, Clinic and Hospital) to be used in determining the upcoming benefit year's CPP designations. Health plans are strongly encouraged to include these providers in their HFP networks. New health plans submitting bids to participate in the HFP should contact Carolyn Tagupa at (916) 324-4695 or ctagupa@mrmib.ca.gov for instructions on completing and returning the traditional and safety net provider lists.

Rates of Payment and Family Value Package

MRMIB will enter into full risk contracts with plans for services to subscribers. Health plans assume 100% of the risk for the cost of covered services. The format for proposing flat per-subscriber fees may be found in Attachment VI, Confidential Attachment – Rates of Payment in the Model Contract. Plans must provide both one- and two-year rate requests for the region(s) of the state in which their proposed service areas fall. A map of the regions used in the Program is included in Attachment VI.

For children ages one through eighteen years, MRMIB will pay a child rate to participating plans on a per enrolled child per month basis. In the first month of enrollment, the negotiated child rate will be paid for subscribers with effective dates of coverage on the first through the fifteenth day of the month. No payment will be made for the first partial month of coverage for subscribers whose coverage begins on the sixteenth day or later. Enrolled infants under the age of one year will be paid at a rate that is 2.78 times the child rate negotiated with each plan for children 1-18 years old in the same region or county. Infants born to mothers enrolled in the Access for Infants and Mothers (AIM) program and automatically enrolled in the HFP health plans matching their mothers' AIM health plans will be covered at a separate negotiated flat rate for the period from birth through the end of the second month of life.

MRMIB uses the Family Value Package (FVP), described in section 2699.6500 (1) of the HFP regulations, to determine a combination of health, dental, and vision plans that provide the best value for HFP subscribers in each county. The calculated value of the package is the benchmark against which each plan's rate proposal (excluding the rate for AIM-linked infants) will be evaluated. Before the FVP process commences, MRMIB staff and its actuary, PricewaterhouseCoopers, will analyze plan rate requests and supporting documentation provided in the Rate Development Template and may place quality assurance calls to plans in January. MRMIB may then negotiate plan-specific rates with potential plans in February 2005. The FVP process is iterative in nature and typically consists of three rounds of rate submissions and negotiations over the course of approximately three weeks. Further details on the FVP process will be sent to plans involved in rate negotiations before the start of the process.

Note: MRMIB is soliciting proposals prior to the enactment of the 2005-06 State budget. Implementation of the contract is contingent on appropriation and continued allocation of state and federal funds for the Healthy Families Program.

Contract Term

The term of the contract is for three years, from July 1, 2005 through June 30, 2008. At the option of the State, the contract may be renewed for two additional one-year terms.

Due Dates for Plan Submissions

Proposals from plans are due on two different dates: **3:00 p.m. Friday, December 10, 2004** for certain documents, and **5:00 p.m. Thursday, January 6, 2005** for the remainder. Details are included in "Documents to be Submitted to MRMIB," which is included in this solicitation notice. **Late submissions will not be accepted.**

In addition, plans submitting proposals for Rural Health Demonstration Projects must submit those proposals no later than **5:00 p.m. Friday, January 14, 2005**. See Enclosure 9 for details.

Contracting Process

The HFP enabling legislation exempts MRMIB from all provisions of state law related to competitive bidding. MRMIB will conduct a fair, open and rigorous competition, including a competitive negotiation process, for the award of contracts.

This solicitation package is being made available to all currently participating HFP plans and all plans that have expressed interest in being HFP contractors. The Model Contract (Enclosure 1) and supporting documents describe the health services, customer service, quality measures, and performance standards MRMIB is seeking to purchase. In preparing its proposal, a potential plan may request redline changes to the Model Contract. These requested changes will be subject to negotiation with MRMIB staff and will be one of the factors used in selecting participating plans.

After the release of this solicitation and prior to the first due date for submission of proposals, all interested health plans currently not participating in HFP should arrange to meet with MRMIB staff to discuss their interest in the program and the requirements of this solicitation. Potential new plans should contact Joyce Iseri, Chief Deputy Director, at jiseri@mrmib.ca.gov or (916) 324-4695 to schedule a meeting.

Bidder's Conference

MRMIB will hold a bidder's conference on **Tuesday, November 9, 2004, from 1 p.m. to 4 p.m. in the auditorium of the State Personnel Board, 801 Capitol Mall, Sacramento, California**. MRMIB staff will review the model contracts for health, dental, and vision plans and answer questions from plans. The RHDP solicitation will also be covered as the last agenda item. Notes from the bidder's conference, including answers to key questions raised at the bidder's conference, will be sent to all interested parties. If you plan to attend the bidders' conference, please notify Dennis Gilliam, Contracts Administrator, at dgilliam@mrmib.ca.gov by **November 5, 2004**.

Selection of Plans

The HFP authorizing statute permits MRMIB to select health plans for participation in the program and instructs MRMIB to contract with a broad range of health plans. The statute further gives priority to those plans which have providers located in those areas of the State where uninsured children in the target population reside.

All proposals will be reviewed in their entirety using the following criteria:

1. All wording changes requested by the plan in the language of the Model Contract and Model Evidence of Coverage, including (a) those that indicate the plan's inability or unwillingness to meet performance and quality standards or to accept other contractual terms and/or language; and (b) proposed improvements to the service levels and/or terms of the Model Contract.

2. The network of providers and facilities available for subscriber choice, as demonstrated by the plan's completed Geographic Area Grid (Attachment I), Provider Directory, and network capacity chart (Enclosure 2, Health Plan Fact Sheet and Network Capacity Chart).

3. The customer service features of health plan operations as demonstrated in responses provided in the Health Plan Fact Sheet, the Cultural and Linguistic Service Report, and any proposed Model Contract changes that affect issues related to customer service.

4. The ability to meet program and regulatory timeframes for implementation (such as Evidence of Coverage or Certificate of Insurance), as demonstrated by submission of a complete proposal, and any proposed Model Contract changes that affect the timing of implementation.

5. The cost effectiveness of the health plan's proposal, as demonstrated by the plan's cost to deliver benefits to subscribers (price) relative to services offered; the plan's experienced loss ratio in the program, if any; the plan's Rate Development Template; and any wording changes requested by the plan to the provisions of the Model Contract that affect price.

6. The ability of a health plan to meet program quality and performance standards, as demonstrated by such factors as HEDIS® and CAHPS® data for a plan.

Individual factors will not be given specific numbers of points in the evaluation process. Proposals will be evaluated in their entirety. The evaluations will be comparative. During the review process, the State may enter into negotiations with a potential health plan on the contents of the proposal submission, including its rate proposal. The State reserves the right to accept a proposal as submitted. Submission of a supplemental proposal to participate in the Rural Health Demonstration Project will neither advantage nor disadvantage a plan.

Staff will prepare an analysis of the proposals for the Board, which will select health plans based on assessment of the best overall value to the State. **Currently, the Board is scheduled to select health plans to participate in HFP at its March 2, 2005 meeting but reserves the right to schedule selection on a different day.**

All potential health plans selected for participation or continuing participation in HFP should note the following:

- By **April 1, 2005,** plans must have their service areas for HFP coverage approved by their regulatory entities (DMHC or DOI) in order to be a plan choice in those service areas during the HFP open enrollment for the 2005-06 benefit year. Refer to Attachment I, Geographic Area Grid Instructions, in the Model Contract for further details.

- By **April 15, 2005,** new plans selected for participation are encouraged to have their Evidence of Coverage/Certificate of Insurance (EOC/COI) booklets and Provider Directories approved and available for distribution to interested subscribers by the start of the open enrollment period (April 15 through May 31, 2005).

- By **June 1, 2005,** plans must have their EOC/COI booklets, Provider Directories, and any collateral materials approved by DMHC or DOI and ready for distribution.

- Potential HFP plans should time their regulatory filings to coincide with these dates. Entities unable to meet these timelines may not be eligible to participate. The first effective date of coverage will be July 1, 2005.

MRMIB Contact

Questions on this solicitation should be addressed to Joyce Iseri, Chief Deputy Director, at jiseri@mrmib.ca.gov or (916) 324-4695. New plans interested in participating in the Healthy Families Program should contact her prior to submitting a proposal. We look forward to working with you.

Rev. Solicitation letter/10-28-04

HFP Health Plan Model Contract and Proposal Solicitation
7/1/05 – 6/30/08
Documents to be Submitted to MRMIB

Summary of Due Dates for Receipt by MRMIB

- **3 p.m. Friday, December 10, 2004:**
    - Signed Geographic Area Grid, Zip Code Workbook, and supporting documentation (Enclosure 1, Attachment I)
    - 2005-06 Evidence of Coverage/Certificate of Insurance (Enclosure 1, Attachment VII)
    - Signed 2005-06 Plan Fact Sheet (Enclosure 2)
    - Health Plan Payment for Vaccinations (Enclosure 4)
    - Cultural and Linguistic Services Report (Enclosure 5)
- **5 p.m. Thursday, January 6, 2005 – all other documents, including:**
    - Signed HFP Model Contract, including a summary of proposed redline changes and a redline version of the model contract (Enclosure 1)
    - Signed Debarment Certification (Enclosure 1, Attachment V)
    - Requested Rates of Payment (Enclosure 1, Attachment VI)
    - Plan Description, Comparative Chart and Language Grid (Enclosure 3)
    - Signed Contractor Certification (Enclosure 6)
    - Signed State Supported Services Contract (Enclosure 7)
    - Signed Rate Development Template (Enclosure 8)
- **5 p.m. Friday, January 14, 2005 – Rural Health Demonstration Project proposals (see Enclosure 9 for details)**

A complete proposal consists of the items listed in these instructions. Paper and electronic versions of proposals must be **received** by MRMIB no later than the specified dates and times. **Note that the December 10 submission is due by 3 p.m., not 5 p.m.** Unless instructed otherwise, please submit three paper copies of all documents in three-ring binders to Joyce Iseri at MRMIB, 1000 G Street, Suite 450, Sacramento, CA 95814. Also send an electronic copy to jiseri@mrmib.ca.gov. Please send the Geographic Area Grid (Attachment I) and Rate Development Templates (Enclosure 8) to the addresses identified below in Items 2.c and 10, respectively.

1. **Cover Letter.** This letter should be on the plan's letterhead and should be signed by a person able to enter into contracts on behalf of the plan. The letter should include the name, title, phone, fax, and e-mail of the contact person for the plan.

2. **Model Contract (Enclosure 1).** Enclosed are copies of the 2005-08 Model Contract as well as a signature page (STD 213) that lists exhibits and attachments. Plans should carefully review the contract before signing. Return a complete copy of Enclosure 1 (STD 213 cover sheet, Exhibits A through E, and Attachments I through VII). Be sure to complete all documents and make sure the cover sheet is signed and includes the signatory's name and address. If your plan is selected for participation in HFP, MRMIB staff will prepare the final contract and return it to you for signature on the final contract.

   If your plan is proposing any changes to the model contract provisions, your submission must include the following:

   - A "redline" version of the model contract, with language proposed to be deleted shown as ~~strikeout~~ and new language proposed to be added **underlined in bold type**. Show requested redline changes in the margin of the model contract or, if lengthy, on a separate sheet of paper immediately following the page with the requested change. Plans are encouraged to discuss any significant proposed changes to the model contract with Joyce Iseri prior to submission.

   - A summary of your plan's proposed redline changes, attached to the front of the redline version. The summary should identify the exhibit or attachment, contract item number, page number, a short description of the proposed redline change, and the rationale for the change. Submissions without a summary of redline changes will be considered incomplete.

   Please note that the following components of Enclosure 1 require plans to provide information and/or signatures:

   a. **Contract Cover Sheet (STD 213).** The signature page of the Model Contract requires plans to provide "fill in the blank" information, including signatory's name and address. All such areas should be completed prior to submission. A signature is required to indicate that the proposal is on behalf of the plan.

   b. **Exhibit D, Special Terms and Conditions.** Please provide the information requested on page 6 for your plan's contact person.

   c. **Geographic Area Grid and Zip Code Workbook (Attachment I).** Included in the package are instructions for filling out Attachment I, the Geographic Area Grid. For plans currently participating in HFP, the current geographic areas served by your plan for the 2004-2005 contract year and a blank Geographic Area Grid are included. Please have a responsible plan official complete and sign Attachment I for the 2005-2006 contract year. Currently participating plans will also receive a copy of the Zip Code Workbook, including a plan-specific zip code listing that shows counties with partial areas of coverage for the 2004-05 contract year. A responsible plan official will need to review and sign the Current

Zip Code listing and state whether any zip codes will be added to or deleted from your plan's area of coverage.

New plans should follow the instructions in Attachment I for completing the Proposed Geographic Area Grid and Zip Code Workbook.

By April 1, 2005, all new plans and any current plan proposing to change any geographic areas or zip codes must obtain approval of new service areas from the Department of Managed Health Care or Department of Insurance, in order to be an available plan during open enrollment. Refer to the Attachment I instructions for further details. Please submit a hard copy of the 2005-06 Geographic Area Grid, the Zip Code Workbook, and supporting documentation to Sarah Soto-Taylor, MRMIB Eligibility Manager, and an electronic copy to wsanchez@mrmib.ca.gov, by 3 p.m. December 10, 2004.

d. **Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion (Attachment V).** Please have an authorized person sign and date the certification.

e. **Confidential Rates of Payment (Attachment VI).** Submit one- and two-year rate requests for regions of the state your plan proposes to serve. Rates should be stated on a per child per month basis and developed using the Rate Development Template (Enclosure 8). Do not enter a rate for infants. If your plan is also authorized to participate in the Access for Infants and Mothers (AIM) program for 2005-06 and 2006-07, complete Part II to request a lump-sum rate for infants born to mothers enrolled in AIM. Requested rates must correspond to information reported in the Rate Development Templates (Enclosure 8).

f. **Evidence of Coverage/Certificate of Insurance (Attachment VII).** MRMIB, in consultation with DMHC, has developed a model EOC/COI to expedite the development and review of a plan's EOC/COI. Although use of the model EOC/COI is optional for plans, MRMIB encourages its use to facilitate the coordinated MRMIB and DMHC review process. The model EOC/COI is consistent with the benefits listed in HFP regulations and Knox-Keene Act requirements. Some sections of the model EOC/COI have been left blank to allow plans to insert their customized information. Instructions for a plan to either use the model EOC/COI or develop its own EOC/COI are included.

3. **Completed and Signed Plan Fact Sheet (Enclosure 2).** The fact sheet has been revised to clarify and delete some previous questions. The Network Capacity Chart is now page 3 of this document. For each county in which your plan will participate in the HFP, please provide the number of pediatric and adolescent primary care practitioners in your network and the number and percentage of practitioners that are accepting new patients. Also provide the estimated number of patients that can be served in each county with your network. Make sure page 7 is signed by a person authorized to sign on behalf of your plan.

4. **HFP Provider Directory.** Please include the most current provider directory for the network that is or will be available to HFP subscribers in your plan's service area.

5. **Plan Description, Comparative Chart and Language Grid (Enclosure 3).** Health plans currently participating in HFP should follow instructions in Part A, while new health plans should follow Part B. Current plans will receive a copy of the plan description that is included in the June 2004 HFP Handbook to review and update if necessary, making any corrections in red ink. On the verification form, please indicate if any changes were made to the plan description or comparative chart. New plans must develop a plan description and answer questions on the comparative chart and language grid.

6. **Payment for Vaccinations (Enclosure 4).** Please answer questions on your plan's payments for vaccinations.

7. **Cultural and Linguistic Services Report (Enclosure 5).** Please respond to the questions on the cultural and linguistic requirements. This report will serve two purposes: (a) fulfill the reporting requirement in the 2004-05 contract for currently participating plans; and (b) provide information on the C&L services of current and new plans proposing to serve HFP subscribers in the 2005-08 contract period.

8. **Contractor Certification Clauses (Enclosure 6)**. All plans submitting a proposal must complete and sign this certification form.

9. **State Supported Services Model Contract (Enclosure 7).** Pursuant to federal regulations, state supported services may not be included in the same contract as federally funded SCHIP services. The attached contract for State Supported Services breaks out these state-funded services into a separate agreement. Please ensure that the cover sheet is signed and that Attachment I is completed.

10. **Rate Development Templates (Enclosure 8).** All plans must complete the RDT in Part A to support the rates requested in Attachment VI. Note the new Schedule 10 on provider incentives and pay for performance components. Your plan's actuary must sign Schedule 11 to certify that the experience for 2003-04 is accurate and that the assumptions used to project costs are reasonable. Only those health plans that have AIM contracts for 2005-06 and 2006-07 must complete the supplemental RDT (Part B) on costs for infants in the first 60 days of life. Make sure that Schedule 6 in Part B is signed by your actuary. Mail a paper copy of the signed Schedule 11 and Schedule 6 (if applicable) to Stuart Busby, Financial Operations Officer, MRMIB, 1000 G Street, Suite 450, Sacramento, CA 95814. Send an electronic version of the complete RDT via e-mail to sbusby@mrmib.ca.gov. All documents must be received by 5 p.m. January 6, 2005.

If you have any questions regarding these submissions, please call Joyce Iseri at (916) 324-4695 or e-mail jiseri@mrmib.ca.gov.

Enclosures

1. HFP Model Contract

    - STD 213 cover sheet
    - Exhibit A – Scope of Work
    - Exhibit B – Budget Detail and Payment Provisions
    - Exhibit C – General Terms and Conditions
    - Exhibit D – Special Terms and Conditions
    - Exhibit E – Federal Terms and Conditions
    - Attachment I – Geographic Area Grid
    - Attachment II – Provider Data File Requirement
    - Attachment III – Schedule of Performance Measures
    - Attachment IV – Translated Process Flowchart
    - Attachment V – Debarment Certification
    - Attachment VI – Confidential Rates of Payment
    - Attachment VII – Evidence of Coverage/Certificate of Insurance

2. 2005-06 Health Plan Fact Sheet and Network Capacity Chart

3. HFP Plan Description, Comparative Chart, and Language Grid

    A. For Health Plans with a 2004-05 HFP Contract
    B. For Health Plans Not Currently Participating in HFP

4. Health Plan Payment for Vaccinations

5. Cultural and Linguistics Services Report

6. Contractor Certification Clauses

7. State Supported Services Model Contract for 2005-08

8. Rate Development Templates

    A. Rate Development Templates (to be completed by all health plans)
    B. Rate Development Template for AIM-linked Infants (to be completed only by health plans participating in both HFP and AIM)

9. Rural Health Demonstration Project Solicitation for 2005-06 and 2006-07

STATE OF CALIFORNIA

ENCLOSURE 1

STANDARD AGREEMENT

STD 213 (Rev 06/03)

HFP HEALTH PLAN MODEL CONTRACT 2005-2008

AGREEMENT NUMBER
05MHF000

REGISTRATION NUMBER

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME
Managed Risk Medical Insurance Board

CONTRACTOR'S NAME

2. The term of this Agreement is: July 1, 2005 through June 30, 2008

3. The estimated amount of this Agreement is: **$**

4. The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

Exhibit A – Scope of Work	XX page(s)
Exhibit B – Budget Detail and Payment Provisions	XX page(s)
Exhibit C – General Terms and Conditions	XX page(s)
Exhibit D – Special Terms and Conditions	XX page(s)
Exhibit E – Federal Terms and Conditions	XX page(s)
Attachment I – Geographic Area Grid	XX page(s)
Attachment II – Provider Data File Requirement	XX page(s)
Attachment III – Performance Measures	XX page(s)
Attachment IV – Translated Process Flowchart	XX page(s)
Attachment V – Debarment Certification	XX page(s)
Attachment VI – Confidential Rates of Payment	XX page(s)
Attachment VII – Evidence of Coverage/Certificate of Insurance	XX pages(s)

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

ADDRESS

STATE OF CALIFORNIA

AGENCY NAME
Managed Risk Medical Insurance Board

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Dennis Gilliam, Contracts Administrator

ADDRESS
1000 G. Street, Suite 450, Sacramento, CA 95814

California Department of General Services Use Only

☐ Exempt per:

EXHIBIT A
SCOPE OF WORK
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EXHIBIT A
SCOPE OF WORK

I. INTRODUCTION

A. Act and Regulation

This Agreement is in accord with and pursuant to Section 12693 et. seq., Part 6.2 of Division 2 of the California Insurance Code, which establishes the Healthy Families Program (hereinafter the Program). The Agreement is also in accord and pursuant to Title XXI of the Social Security Act and its implementing federal regulations, which establish the State Children's Health Insurance Program and provide authorization and federal funding for the Healthy Families Program, and Title 10, Chapter 5.8 of the California Code of Regulations (hereinafter Program Regulations). Terms and conditions used in the Program Regulations shall have the same and identical meanings in this Agreement.

B. Health Care Service Plan **(HMO)**

This Agreement is entered into by the Contractor and the State for the purpose of providing health coverage for subscribers determined to be eligible by the State. The method of delivery of the insured health benefits shall be a health maintenance organization. The Contractor agrees to provide and maintain the health maintenance organization.

OR

B. Exclusive Provider Organization **(EPO)**

This Agreement is entered into by the Contractor and the State for the purpose of providing health coverage for subscribers determined to be eligible by the State. The method of delivery of the insured health benefits shall be an exclusive provider organization. The Contractor agrees to provide and maintain the exclusive provider organization.

C. Geographic Areas Covered

1. The Contractor's participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's licensed service area accepted by the State. These geographic areas are described in Attachment I: Geographic Area Grid.

2. Geographic coverage in the Program may be changed only upon written approval by the State. The Contractor shall request such approval in writing at least sixty (60) days prior to the date the

change will take place and shall include documentation from the state licensing agency that approved the changes to the Contractor's licensed service area.

3. If the change requested is to withdraw from an area due to a plan-initiated licensure change or removal, the State shall cease new enrollment of subscribers in the area and the Contractor shall continue to maintain and provide services to subscribers in the area until the end of the benefit year.

4. If the change requested is to withdraw from an area due to a plan-initiated licensure change or removal for a date that is not concurrent with the Program's open enrollment, then the Program will hold a special open enrollment pursuant to Exhibit B, Item I.C.

D. Changing Health Care Providers

1. The Contractor's organization shall consist of the list of health care providers to be provided to the State. These providers (institutional and professional) are listed in the Contractor's Provider Directory. The Contractor agrees to provide copies of the Provider Directory to the State upon request.

2. Health care providers shall be deemed added to or deleted from the Contractor's Provider Directory as contracts between the Contractor and health care providers begin or end. If such contract activity either opens a new zip code to the coverage contemplated by this Agreement or would materially impair the Contractor's capacity to perform under this Agreement**,** the Contractor shall give not less than sixty (60) days written notice to the State and shall implement the change only upon written approval by the State.

3. In addition to any other rights the subscriber may have under existing law, at the State's option, and in consultation with the Contractor, the Contractor agrees to maintain the availability of those providers listed at any time during the benefit year in the Contractor's Provider Directory until the end of the benefit year, if elimination of the provider would impact twenty-five (25) or more subscribers enrolled with the Contractor through the Program. For the purpose of this section, the term "provider" may refer to a solo practitioner, a medical group or a clinic.

4. Item I.D.3. above shall not apply if the withdrawal of a provider from the Contractor's network was done at the request of the provider or is part of the Contractor's activities to obtain or retain National Committee for Quality Assurance/Joint Commission on the

Accreditation of Healthcare Organizations (NCQA/JCAHO) accreditation, or is initiated by the Contractor for cause.

E. Term of Agreement

The term of this Agreement shall be from July 1, 2005 through June 30, 2008. At its sole discretion, the State may exercise the option to negotiate an Agreement for two subsequent one-year terms. The State shall exercise this option no later than sixty (60) days prior to the expiration date of this Agreement. Such extension shall be by an amendment to this Agreement. Reimbursement rates applicable to each subsequent one-year term shall be negotiated by the parties and included in the amendment. Renewal of the Agreement is contingent upon successful performance by the Contractor, as determined by the State at its sole discretion.

II. ENROLLMENT

A. Eligibility

1. All subscribers who are determined eligible by the State in accordance with the Act and Program regulations are eligible to enroll in a program health plan. The State certifies that its enrollment process will not be prejudicial to the Contractor or other participating health plans.

2. Upon notification by the State, the Contractor agrees to serve subscriber parents in the Program. Rates and other contractual terms shall be negotiated between the Contractor and the State prior to implementation and shall be implemented through an amendment to this Agreement.

B. Enrollment of Infants Born to Women Enrolled in the Access for Infants and Mothers (AIM) Program (only for health plans that are also AIM contractors)

1. The Contractor shall notify any woman enrolled in the AIM program with the Contractor that her newborn will be eligible for automatic enrollment in the Healthy Families Program from birth, provided the State receives the information and required family child contribution specified in Article 2, Section 2699.6608, subsection (a) of the Program regulations by the end of the eleventh month following the month of birth.

2. Within five days of the Contractor's being notified of the birth of an infant born to a woman enrolled in the AIM Program with the Contractor, the Contractor shall provide the State with the following

information: infant's name, infant's date of birth, infant's address, infant's gender, mother's name and identification number, infant's birth weight, and, if known, infant's primary care provider. This information shall be provided in a manner and format to be specified by the State.

3. If an infant is in need of immediate health care services and the Contractor has knowledge of this need at any time up to 5:00 p.m. on the tenth day of the second full calendar month of the infant's life, the Contractor shall notify the State of the infant's need for services in accordance with the requirements of Article 2, Section 2699.6608, subsection (f) of the Program regulations, and shall provide the information specified in Section 2699.6608, subsection (a) within the time frame specified in Section 2699.6608, subsection (f).

C. Conditions of Enrollment

1. The Contractor agrees to enroll all subscribers referred by the State on the date specified by the State.

2. The State shall notify the applicant of enrollment with the Contractor and the effective date of coverage by the Contractor. Except for infants born to women enrolled in the AIM Program with the Contractor and as specified in Item II.C.3., the State shall notify the Contractor of new enrollees no later than ten (10) days prior to the subscriber's effective date of coverage.

3. The Contractor agrees that in special circumstances the State may provide less than ten days' notice prior to a subscriber's effective date of coverage. Special circumstances shall be at the discretion of the State, but Contractor shall be notified of the special circumstance.

D. Disenrollment

1. The Contractor agrees to disenroll subscribers when notified to do so by the State on the date specified by the State.

2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

E. Commencement of Coverage

Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the State as the effective date of coverage.

F. Identification Cards, Provider Directory, and Evidence of Coverage

1. Except for infants born to women enrolled with the Contractor in the AIM Program and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, Provider Directory, and Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklet relating to accessing services, or a magnet listing the telephone number to call to schedule an appointment with a provider.

2. For infants born to women enrolled in the AIM Program with the Contractor and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall provide the Identification Card, Provider Directory, Evidence of Coverage booklet and other materials described in Item II.F.1. to applicants on behalf of subscribers no later than ten (10) days from the date the Contractor is notified of the enrollment.

3. a. In addition to the instances described in Items II.F.1. through II.F.2., above, the Contractor shall, by April 1 of each year, issue to each applicant on behalf of the subscribers enrolled in the Contractor's plan an updated Provider Directory, and either an updated Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year, or a letter describing any changes to the benefits package that will go into effect at the beginning of the next benefit year.

b. In any year in which an updated Evidence of Coverage booklet is not issued by April 1, the Contractor shall issue an

updated Evidence of Coverage booklet by June 15 to each applicant on behalf of the subscribers enrolled in the Contractor's plan.

c. The Contractor shall obtain written approval by the State prior to issuing the updated Evidence of Coverage booklet and the letter describing changes in the benefit package. The letter shall be submitted to the State by March 1 for review and approval.

d. By July 1 of each year, the Contractor shall submit to the State five copies of the updated Evidence of Coverage booklet and one copy of the updated Provider Directory.

4. The Contractor's Provider Directory shall be updated and distributed by the Contractor to applicants on behalf of subscribers whenever there is a material change in the Contractor's provider network.

5. The Contractor's Provider Directory shall indicate the language capabilities of the providers.

6. The Contractor shall provide a copy of the Contractor's Evidence of Coverage booklet and Provider Directory to any person requesting such materials, by telephone or in writing, within ten (10) days of the request.

7. Written informing material provided to subscribers shall be at a sixth grade reading level or at a level that the Contractor determines is appropriate for its subscribers and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

G. Primary Care Physician Assignment **(HMOs only)**

1. The State shall provide the Contractor with the name of each subscriber's chosen primary care physician, if the name of the primary care provider is listed on the Program application. The Contractor agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) days of the effective date of coverage in the plan. If the Contractor assigns a primary care physician to a subscriber, the Contractor shall use a fair and equitable method of assignment from the Contractor's physician network and shall promptly notify the subscriber of the selection and the opportunity to change the assigned primary care physician.

Such method of assignment shall take into account the geographic accessibility and language capabilities of providers. The Contractor also agrees to notify the primary care physician promptly that he or she has been chosen by the subscriber or assigned by the Contractor.

2. Whenever the Contractor assigns a subscriber to a clinic, the Contractor shall notify the subscriber of his or her right to select a new primary care provider. If a subscriber selects a primary care provider who is affiliated with a clinic and the assignment of the subscriber is made to the clinic pursuant to Insurance Code Section 12693.515, the Contractor shall inform the subscriber that he or she has been assigned to the clinic and has a right to select a new primary care provider immediately or at any future time, including such time as the selected primary care provider is no longer affiliated with the clinic. The Contractor shall notify the subscriber of his or her rights immediately after the assignment to the clinic has been made.

H. Right to Services

Possession of the Contractor's Identification Card confers no right to services or other benefits of the Program. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the Program.

I. Open Enrollment

The Contractor agrees to participate in an annual open enrollment process during which subscribers may transfer between health plans.

J. Enrollment Data

The State and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept this information via EDI. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets.

2. The Contractor agrees to accept written confirmation of enrollments from the State plan liaisons, in the event system errors cause enrollment transactions to be delayed. The State agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the failed or delayed enrollment transaction can be generated and sent to the Contractor.

3. The State shall develop an electronic bulletin board system, available 24 hours a day, excluding maintenance periods that usually will be held on Sundays, to provide the Contractor with enrollment reports.

4. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.

5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist of a record count of the different record types in the weekly enrollment file. The State shall also transmit to the Contractor enrollment and data files on a weekly basis (on Saturday or Sunday) reflecting the prior week's activity. The Contractor may use the data files to reconcile and validate weekly activity.

6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Standard Time each Monday or, when Monday is an official State holiday, by 4:00 a.m. Pacific Standard Time Tuesday.

7. On a monthly basis, the State shall provide audit files for the Contractor, including, but not limited to, currently active subscribers. The audit files shall normally be provided by the third Monday of the month following the month for which data are being reported. If unexpected circumstances cause a delay in the provision of the audit files, the State shall notify the Contractor.

8. The Contractor agrees to reconcile its enrollment data using the monthly data files sent by the State. The Contractor shall report any enrollment discrepancies to the State, in a format approved by the State, within sixty (60) days from the date the monthly audit file is provided to the Contractor. The State shall not be liable for any discrepancies reported by the Contractor after this 60-day period.

9. The State shall transmit the files described in Items II.J.1., II.J.5., and II.J.7. to the Contractor at no charge.

10. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Items II.J.5. and II.J.7. above within six months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Items II.J.5. and II.J.7. above at the rate of $85 per hour or $250 per report or file, whichever cost is greater. The State shall waive the assembly and retransmission fee if the State determines that the original transmission file was corrupted or unusable.

11. With respect to Items II.J.5. and II.J.7. above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There shall be no charge for the services of the State's plan liaison.

12. Prior to commencing work requested by the Contractor under Item II.J.10., the State shall provide a cost estimate to the Contractor.

13. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.

14. The State shall conduct at least one meeting for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.

15. The Contractor agrees either to use the Program's unique Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

K. Network Information Service

1. The Contractor agrees to provide, to the best of the Contractor's ability, complete and accurate data on its provider network in an electronic format to be determined by the State. The Contractor understands that the minimum data set requested by the State shall include the information on the Contractor's network outlined in Attachment II, Provider Data File Requirements. The information described in Attachment II may be expanded by the State with no less than ninety (90) days notice by the State. The Contractor agrees to provide additional data elements, as requested by the

State, to the best of its ability. The Contractor understands that the State intends to use information provided pursuant to this section to assist potential and current applicants and subscribers in selecting a health plan, and that information provided to the State will be shared with the public.

2. The Contractor agrees to provide the provider network information listed in Attachment II to the State on a quarterly basis. The Contractor may update its provider network information on a monthly basis. The Contractor is required to provide data for the creation of the database to the State between the 11th and 25th of any submission month.

3. If the Contractor is unable to provide electronic files in the specified provider network formats, the State agrees to offer the Contractor data capture services at the rate of $25 per hour.

4. If the Contractor so requests, the State agrees to offer the Contractor an unscheduled update to the provider network information at the rate of $500 per update.

L. Traditional and Safety Net Providers

1. The Contractor agrees to establish, with traditional and safety net providers as described in Article 4 of the Program regulations, network membership and payment policies which are no less favorable than its policies with other providers.

2. The Contractor shall, on or before February 15 of each year, report to the State on the number of subscribers who selected traditional and safety net providers as the subscriber's primary care physician in the previous year. The format for the report shall be determined by the State.

3. No later than January 15 of each year, the Contractor shall provide the State with a list of those traditional and safety net providers (as described in Article 4 of the Program regulations) that have signed contracts with the Contractor to provide services to Program subscribers.

4. The Contractor assures the State that it has signed contracts with all providers the Contractor has listed in its Traditional and Safety Net Provider Report described in Item II.L.3. above, and shall provide the State with copies of the contracts, if requested by the State.

M. Public Awareness

1. The Contractor agrees to engage in marketing efforts designed to increase public awareness of and enrollment in the Program. At a minimum these efforts shall include the following activities. The Contractor shall publicize its participation in the Program through its internal provider communications and through its general membership communication publications. All public awareness efforts must be approved by the State before being released in public and must be in compliance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments and applicable regulations. In the event that the State does not notify the Contractor in writing, with the reasons the marketing materials are not approved, within sixty (60) days of receipt by the State, the materials shall be deemed approved.

2. The Contractor is prohibited from directly, indirectly, or through its agents, conducting in person, door to door, mail or telephone solicitation of applicants for enrollment.

3. a. By September 1, 2005, the Contractor agrees to submit to the State for its approval, in a format determined by the State, a marketing plan that covers the term of this Agreement.

   b. The marketing plan shall include the Contractor's mission statement, a written description of proposed marketing activities and locations, a listing of all proposed marketing materials to be used, and proposed locations for distribution, including ancillary components such as scripts. Upon request by the State, the Contractor shall submit other information, such as examples of previously approved marketing materials currently being used.

   c. The marketing plan shall be in compliance with all applicable statutes and regulations, as well as the Program's marketing guidelines.

4. For the 2006-07 and 2007-08 benefit years, the Contractor agrees to submit to the State for its approval, in a format determined by the State, any proposed updates or amendments to its then-approved marketing plan.

5. If the Contractor chooses to provide application assistance, the plan must have an approved application assistance plan on file with the State.

III. CUSTOMER SERVICE

A. Telephone Service for Subscribers

The Contractor agrees to provide a toll free telephone number for applicant and subscriber inquiries. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00 p.m. Pacific Standard Time. The Contractor shall provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor shall have the capability to provide telephone services via an interpretive service for all limited English proficient (LEP) persons.

B. Grievance Procedure **(DMHC)**

Department of Managed Health Care Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. These procedures shall be described in the Contractor's Evidence of Coverage booklet.

2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of medical benefits in the Program.

OR

B. Grievance Procedure **(DOI)**

Department of Insurance Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall include all features required for health care service plans pursuant to the

Knox-Keene Health Care Service Plan Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's Certificate of Insurance booklet.

2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of medical benefits in the Program.

C. Cultural and Linguistic Services

1. Linguistic Services

a. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

b. The Contractor shall provide twenty-four (24) hour access to interpreter services for all (LEP) subscribers seeking health services within the Contractor's network. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor's procedures must include ensuring compliance of any subcontracted providers with these requirements. Activities that the Contractor may undertake to assure compliance of subcontracted providers include, but are not limited to, employing competent bilingual or multilingual staff who can

interpret for providers and subscribers, and using competent contracted community-based organizations for interpreter services.

c. When the need for an interpreter has been identified by the provider, or requested by a subscriber the Contractor agrees to provide a competent interpreter for scheduled appointments. The Contractor shall avoid unreasonable delays in the delivery of health care services to persons of limited English proficiency. The Contractor shall instruct the providers within its health maintenance organization network to record the language needs of subscribers in the medical record.

d. The Contractor agrees that subscribers shall not be required to or encouraged to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall encourage the use of qualified interpreters. The Contractor agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the request or refusal of language or interpreter services is documented in the medical records of providers in the Contractor's health maintenance organization network. Activities that the Contractor may undertake to ensure compliance of providers with this paragraph include, but are not limited to, training its providers on the need to document a request or refusal of interpreter services; supplying providers and their staff with Request/Refusal forms for interpreter services ; supply providers and their staff with chart labels identifying member language needs; implementing an incentive program to reward provider offices that affirmatively attempt to identify language needs of LEP members and record them on the medical charts; conducting reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services; and providing other technical assistance to providers.

e. The Contractor shall inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no

charge; the right not to use family members or friends as interpreters; the right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers; the right to receive subscriber materials as described in Item III.C.2. of this Exhibit; and the right to file a complaint or grievance if linguistic needs are not met.

f. The Contractor shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions. Activities that the Contractor may undertake to ensure the bilingual proficiency of interpreters at medical and non-medical points of contact include, but are not limited to: hiring staff who demonstrate conversational fluency as well as fluency in medical terminology; providing training that will enable staff to take, or assist with gathering, information for an accurate medical history with culturally related consent forms; providing dictionaries and glossaries for interpreters; providing provider staff with consistent interpreter training by experienced and properly trained interpreters; periodically assessing the language proficiency of the plan's identified medical and non-medical staff who have patient contact; conducting audits of provider sites to confirm ongoing language capabilities of providers and staff; and providing other technical assistance to providers.

g. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item II.K. of this Exhibit.

2. Translation of Written Materials

a. The Contractor agrees to translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices

pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided at a sixth grade reading level or as determined appropriate through the Contractor's Cultural and Linguistic Needs Assessment and approved by the State, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for the lesser of five percent (5%) of the Contractor's enrollment or 3,000 subscribers of the Contractor's enrollment in the Program. If the Contractor serves both Medi-Cal and Program subscribers, it is encouraged, where practicable, to translate Program member materials into additional Medi-Cal threshold languages not required by the Program. The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials. Activities that the Contractor may undertake to comply with this paragraph include, but are not limited to, informing LEP subscribers, during the welcome call, of the plan's language assistance services; encouraging members to call the Contractor if they need help in understanding any of the Contractor's written materials; providing an oral translation of the material in a member's preferred language or arranging for this to be done by a competent interpreter service; and making the content of the written materials available in alternative formats such as Braille, CD, and audio cassette.

b. The Contractor shall ensure the quality of the translated material. The Contractor is encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Activities that the Contractor may undertake to ensure the quality of translated materials include, but are not limited to, contracting and using certified translation companies that follow a step-by-step translation

process; performing back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator; having an internal team review committee that includes a medical and/or legal "professional reviewer" who reviews translated materials for cultural appropriateness; and proof-reading and editing of the document by a separate qualified translation editor/proof reader. The Contractor may use computer technology as part of the process for producing culturally and linguistically appropriate translation. Guidelines for developing and producing culturally and linguistically appropriate translations and definitions for the terms used are included in Attachment IV, Translated Process Flowchart.

c. By September 30 of each year, the Contractor shall submit to the State one copy of all materials provided to new subscribers pursuant to Item II.F. for each language in which the materials are translated.

3. Cultural and Linguistic Group Needs Assessment

a. By June 30, 2007, the Contractor agrees to conduct and submit to the State a Cultural and Linguistic Needs Assessment to promote the provision and utilization of appropriate services for its diverse enrollee population. The Needs Assessment report shall include findings from the assessment described in Item III.C.3.b. below and a plan outlining the proposed services to be improved or implemented as a result of the assessment findings, with special attention to addressing cultural and linguistic barriers and reducing racial, ethnic, and language disparities.

b. The Cultural and Linguistic Needs Assessment shall examine the demographic profile of the Contractor's Program enrollees by ethnicity and language to assess their linguistic and cultural needs. The assessment shall be conducted in accordance with guidelines issued by the State and shall examine the language preference of the Program enrollees and other data, including, but not limited to, the health risks, beliefs, and practices of the Contractor's enrollees. The Contractor may conduct the Needs Assessment individually or collaboratively with other plans participating in the Program.

c. The Contractor shall assess the internal systems it has in place to address the cultural and linguistic needs of its

Program enrollment population, including, but not limited to, assessing the Contractor's capacity to provide linguistically appropriate services. The Contractor shall review internal data including complaints and grievances, results from member surveys, diversity and language ability of staff as reflective of the enrollee population, internal policies and procedures, education and training of staff and providers regarding cultural and linguistic competency issues, and, to the extent feasible, utilization and outcome data analyzed by race, ethnicity and primary language. This information shall be examined in relation to and compared with external data for benchmarking and trends.

d. The Contractor agrees to provide an opportunity for representatives of subscribers enrolled in the Program to provide input on the Cultural and Linguistic Needs Assessment. The Contractor may use an existing member advisory committee or community advisory committee for the purposes of providing an opportunity for Program subscribers to provide input. The Contractor shall ensure that the committee used to obtain input from subscribers is representative of subscribers in the program and includes representatives from hard-to-reach populations. The Contractor shall also ensure that the committee holds regular meetings and is provided with adequate resources to support committee activities and support staff.

4. Operationalizing Cultural and Linguistic Competency

a. The Contractor shall develop internal systems that meet the cultural and linguistic needs of the Contractor's subscribers in the Program. The Contractor shall provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.

b. Activities that the Contractor may undertake in developing its internal systems to meet the cultural and linguistic needs of the Contractor's subscribers include: incorporating cultural competency in the Contractor's mission; establishing and maintaining a process to evaluate and determine the need for special initiatives related to cultural competency; developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive

to the needs of the community; assessing the cultural competence of plan providers on a regular basis; establishing a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines; providing an array of communication tools to distribute information to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues); participating with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure that the Contractor maintains current information and an outside perspective in its policies; maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data; and evaluating the effectiveness of strategies and programs in improving the health status of cultural-defined populations.

c. The Contractor shall report, on or before December 10 of each year, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient applicants and subscribers in the Program. This report shall address types of services including, but not limited to, linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers. The Contractor shall also report its efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information may include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers. The report shall also address activities undertaken by the Contractor to develop internal systems, as described in Item III.C.4.b of this Exhibit. The Contractor shall also report on the status of the Contractor's cultural and linguistic activities developed from the Needs Assessment. The format for this report shall be determined by the State.

IV. COVERED SERVICES AND BENEFITS

A. Covered and Excluded Benefits

1. Except as required by any provision of applicable law, only those benefits described in Article 3, Sections 2699.6700 through 2699.6707, of the Program regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the Program regulations shall not be covered benefits. The Contractor shall set out the plan of coverage in an Evidence of Coverage booklet.

2. The parties understand that terms of coverage under this Agreement are set forth in the attached Evidence of Coverage booklet (Attachment VII). In the case of conflicts, terms of coverage set forth in the Evidence of Coverage booklet shall be binding notwithstanding any provisions in this Agreement which are less favorable to the subscriber.

3. The Contractor shall make benefit and coverage determinations. All such determinations shall be subject to the Contractor's grievance procedures.

4. State Supported Services as defined in the program regulations are not covered under this Agreement.

B. California Children's Services (CCS)

1. Medically necessary services that are authorized by the CCS Program to treat a subscriber under the age of nineteen (19) for CCS eligible conditions, once CCS eligibility is determined as defined in Title 22, CCR, Section 41518, are not covered under this Agreement. The Contractor shall identify subscribers under the age of nineteen (19) with suspected CCS eligible conditions and shall refer them to the local CCS office for determination of medical eligibility by the CCS Program. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber under the age of nineteen (19) with a California Children's Services one page (double sided) informational flyer. The State agrees to provide the Contractor with camera-ready copies of the California Children's Services informational flyer.

2. The Contractor shall implement written policies and procedures for identifying and referring subscribers under the age of nineteen (19)

with suspected CCS eligible conditions to the local CCS Program. The policies and procedures shall include, but not be limited to:

a. Procedures for ensuring that the Contractor's providers are informed of the identity of CCS paneled providers and CCS approved hospitals within the Contractor's entire network.

b. Policies and operational controls that ensure that the Contractor's providers perform appropriate baseline health assessment and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a subscriber under the age of nineteen (19) has a CCS eligible medical condition.

c. Policies and procedures to assure that the Contractor's providers refer potentially eligible children to the CCS Program.

d. Procedures that provide for continuity of care between the Contractor's providers and CCS providers.

3. The Contractor shall report to the State the number of subscribers who were referred to the local CCS program. The report is due by July 31 of each year. The format for the report shall be determined by the State.

4. The Contractor shall consult and coordinate CCS referral activities with the local CCS Program in accordance with the required Memorandum of Understanding (MOU) between the Contractor and the local CCS Program.

5. Until eligibility for the CCS Program is established, the Contractor shall continue to be responsible for arranging for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Services which are provided by a CCS paneled provider or approved facility on the date of referral, or afterwards, and which are authorized by the CCS program for a CCS eligible child, shall be paid through the CCS Program at the CCS reimbursement rate retroactively to the provider of services.

6. Once eligibility for the CCS Program is established for a subscriber under the age of nineteen (19):

a. The Contractor shall continue to provide covered primary care and all other medically necessary covered services

other than those provided through the CCS Program for the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.

b. The CCS Program shall authorize and pay for the delivery of medically necessary health care services to treat a subscriber's CCS eligible condition. The CCS authorization, on determination of medical eligibility, shall be to CCS paneled providers and approved facilities, some of which may also be members of the Contractor's network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, Section 42180. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.

c. For the purposes of Item IV.B.6.b., above, initial referral means referral by a Contractor network physician, or by any other entity permissible under CCS regulations.

7. ***(For plans not participating in the Program prior to July 1, 2005)*** By July 1, 2005, the Contractor agrees to develop and submit to the State a signed Memorandum of Understanding (MOU) with the local CCS program in each county in which the Contractor participates in the Program. The MOU shall include the policies and procedures described in Item IV.B.2. The Contractor is willing to sign the draft MOU developed by the State. If the Contractor is unable on July 1, 2005 to submit an MOU signed by both the Contractor and local CCS program, the Contractor agrees to report, in writing, to the State on the first day of each month on the Contractor's progress in obtaining a signed MOU.

C. Mental Health: Family Members

The Contractor agrees to involve appropriate family members in the mental health and/or substance abuse services provided to a subscriber who has experienced family dysfunction and/or trauma to the extent it is required as a course of treatment for the health and recovery of the child.

D. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder

1. The Contractor is not responsible for providing or reimbursing a county for services to treat a subscriber child's serious emotional disturbance or serious mental disorder that are provided or

authorized by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3. The Contractor shall identify subscriber children who potentially have a serious emotional disturbance or serious mental disorder and shall refer them to the County Mental Health Department for determination of medical eligibility. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber child a County Mental Health one-page (double sided) information flyer. The State agrees to provide the Contractor with camera-ready copies of the County Mental Health informational flyer. The Contractor shall assure the State that it will cooperate with the local County Mental Health Department in establishing policies and procedures that will successfully develop the interface between the Contractor and the local County Mental Health Department.

2. The Contractor shall implement the written policies and procedures it has developed in cooperation with County Mental Health Department Programs for identifying and referring children who potentially have a serious emotional disturbance or serious mental disorder to the County Mental Health Department for determination of medical eligibility. These policies and procedures shall include, but not be limited to:

   a. Identification of a specific screening process for identifying and referring subscriber children who potentially have a serious emotional disturbance or serious mental disorder. The County Mental Health Department shall make the final determination of whether the subscriber child has a serious emotional disturbance or serious mental disorder. The MOU shall provide specific time frames for the County Mental Health Department to notify the Contractor about the assessment and determination of whether a subscriber child has a serious emotional disturbance or serious mental disorder.

   b. Procedures to assure that the Contractor and the Contractor's providers have the screening instrument and specific referral protocols to govern referral of subscriber children who potentially have a serious emotional disturbance or serious mental disorder to the County Mental Health Department. These protocols should assure that referral is made at the earliest recognition by the Contractor or the Contractor's providers that the subscriber child may have a serious emotional disturbance or serious mental disorder.

c. A procedure to assure that baseline health and mental health information about the subscriber child is shared between the Contractor and the County Mental Health Department and any County Contract Providers.

d. Procedures that provide for continuity of care between the Contractor and the Contractor's providers and the County Mental Health Department and any County Contract Providers.

e. Procedures that maintain continuity of care for the subscriber child when the subscriber child is a new subscriber child with the Contractor and has an ongoing treatment plan with the County Mental Health Department. This procedure shall include an automatic referral for a new subscriber child who has a treatment plan for serious emotional disturbance or serious mental disorder with the County Mental Health Department.

3. The Contractor shall report to the State the number of children who were referred to the County Mental Health Department. The report is due by July 31 of each year. The format for the report shall be determined by the State.

4. Unless and until eligibility for the County Mental Health Department Programs for children with serious emotional disturbance or serious mental disorder is established, the Contractor shall continue to provide all covered medically necessary health care and case management services for a subscriber child referred to the County Mental Health Department.

5. Once eligibility for the County Mental Health Department Program for children with serious emotional disturbance or serious mental disorder is established for a subscriber child:

   a. The County Mental Health Department will notify the Contractor of the determination, in a time frame consistent with the Memorandum of Understanding.

   b. The Contractor shall continue to provide all other covered services, including, but not limited to, primary care and any medically necessary covered drugs, laboratory and inpatient care, up to the limit of coverage and consistent with the Contractor's mechanism for subscriber conversion of an inpatient day for other less intensive treatment services, and shall work with the County Mental Health Department to

ensure the coordination of services between its primary care providers and the County Mental Health Department and its specialty providers.

c. The County Mental Health Department will authorize the delivery of medically necessary health care services to treat a subscriber child's serious emotional disturbance or serious mental disorder.

6. ***(For plans not participating in the Program prior to July 1, 2005)*** By July 1, 2005, the Contractor agrees to develop and submit to the State a signed Memorandum of Understanding (MOU) with the County Mental Health Department in each county in which the Contractor participates in the Program. The MOU shall include the policies and procedures described in Item IV.D.2. The Contractor is willing to sign the draft MOU developed by the State. If the Contractor is unable on July 1, 2005 to submit an MOU signed by both the Contractor and County Mental Health Department, the Contractor agrees to report, in writing, to the State on the first day of each month on the Contractor's progress in obtaining a signed MOU.

7. Memoranda of Understanding shall include a mediation process to assure that disputes concerning referral or coverage questions, and any other areas of dispute between the Contractor and the County Mental Health Department can be mediated and resolved.

8. Nothing in this section shall be construed to relieve the Contractor of the responsibility to provide mental health care, up to the limits set forth in Article 3 of the Program regulations, for subscriber children who are referred to the County with serious emotional disturbance or serious mental disorder.

E. Other Public Linkages

The Contractor shall, to the extent feasible, create viable protocols for screening and referring subscribers needing supplemental services outside of the scope of benefits described in Article 3 of the Program regulations to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the Contractor and the public programs. Public programs may include but not be limited to: regional centers, programs administered by the Department of Alcohol and Drug Programs, Women, Infants and Children Supplemental Food Program (WIC), lead poisoning prevention and programs administered by local education agencies.

F. Pre-existing Condition Coverage Exclusion Prohibition

No pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.

G. Exercise of Cost Control

The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

H. Copayments

1. The Contractor shall impose copayments for subscribers as described in Article 3 of the Program regulations. The Contractor agrees that copayment maximums as described in Article 3 of the Program regulations shall be applied for each benefit year and shall be renewed on July 1 of each year. The Contractor's Evidence of Coverage or Certificate of Insurance document shall describe the process to be used by applicants on behalf of subscribers to document that the annual two hundred and fifty dollar ($250) out-of-pocket family maximum has been reached.

2. The Contractor shall work with its provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are required. Wnen feasible, the Contractor shall instruct its provider network to offer extended payment plans whenever a family's copayments exceed twenty-five dollars ($25) in one month.

3. The Contractor shall report the number of subscribers who meet the copayment maximum in the previous benefit year by October 1 of each year. The format for the report shall be determined by the State.

4. The Contractor shall implement an administrative process that ensures that the Contractor waives all copayments for American Indian and Alaska Native subscribers in the Program, if the State identifies such subscribers as qualifying for the waiver.

I. Coordination of Benefits

The Contractor agrees to coordinate benefits with other group health plans or insurance policies for subscribers in the Program. The Contractor agrees to work with other plans or insurers to provide no more than one-hundred percent (100%) of subscribers' covered medical expenses. The Contractor shall coordinate such that coverage provided pursuant to this

Agreement is secondary to all other coverage except for Medicaid (Medi-Cal) and Access for Infants and Mothers (AIM).

J. Acts of Third Parties

If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the subscriber or applicant on behalf of a subscriber shall be deemed:

1. To have agreed to reimburse the Contractor to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and

2. To have provided the Contractor with a lien to the extent of the reasonable value of services provided by the Contractor and allowable under Civil Code Section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

K. Workers' Compensation Insurance

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Contractor, then the Contractor shall provide the benefits of this Agreement and the subscriber shall be deemed to have provided the Contractor with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Contractor. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

L. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Items IV.J. and IV.K. of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. The State understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor

may compromise liens as may be reasonable and appropriately consistent with normal business practices.

M. Health Insurance Portability and Accountability Act of 1996 Conformity

The State and the Contractor understand that the coverage provided pursuant to this Agreement constitute creditable coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996. The State shall issue the Certificates of Coverage for disenrolled subscribers.

N. Interpretation of Coverage

The Contractor, in its Evidence of Coverage booklet (Attachment VII), shall provide clear and complete notice of terms of coverage to subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

V. CLINICAL QUALITY MEASURES AND MANAGEMENT PRACTICES

A. Measuring Clinical Quality

1. The Contractor agrees to provide the State annually with audited clinical quality measures as outlined in Attachment III, Performance Measures. The measures to be provided include selected measures from the most recent version of the Health Plan Employer Data and Information Set (HEDIS®) released by the National Committee for Quality Assurance (NCQA), and the number of newly enrolled subscribers who received an initial assessment within the first 120 days of enrollment or an assessment within the 12 months immediately preceding the effective date of coverage.

2. Data on the measures described in Item V.A.1. above shall include data on subscribers enrolled in the Contractor's plan through the Program and shall cover the experience of the previous calendar year. The report shall be due by June 15 of each year and shall be submitted in a format determined by the State. The State hereby notifies the Contractor that compliance with Item V.A.1. and the information received by the State will significantly influence the State's willingness to extend or renew this or subsequent Agreements for provision of service to Program subscribers.

3. All data reported to the State pursuant to Item 1 above shall be audited by a certified NCQA HEDIS® auditor.

4. The Contractor understands that the State may include the results of any of the data included in the reports submitted pursuant to this Item in its annual open enrollment or Program application materials.

5. The Contractor understands that the State intends to collect claims and encounter data from the Contractor during the 2006-07 contract year.

B. Measuring Consumer Satisfaction

1. The Contractor understands that the State intends to conduct an annual consumer satisfaction survey of Program participants using the most recent release of NCQA's version of the Consumer Assessment of Health Plans (CAHPS®). The Contractor further understands that the State intends to conduct an adolescent survey using the Young Adult Health Care Survey (YAHCS), as released by the Child and Adolescent Health Measures Initiative.

2. The Contractor understands that the State will conduct annual CAHPS® and YAHCS surveys, if funding is made available to the State for this purpose, using the services of a vendor selected by the State, hereafter referred to as the CAHPS® Vendor, to collect and analyze CAHPS® and YAHCS data.

3. The Contractor understands that the State intends to release the CAHPS® and YAHCS data to applicants, subscribers and other interested parties. The Contractor understands that the final decision regarding the release of information collected from the CAHPS® and YAHCS surveys shall be made by the State.

4. The State agrees to convene an open Work Group comprised of health plans, State staff, representatives of the State's Quality Improvement Work Group, and the staff of the CAHPS® Vendor to review the survey process and discuss the format and content of any data to be publicly released. The Work Group shall meet periodically during the term of this Agreement in locations throughout the State.

5. If funding is made available, the State shall pay the CAHPS® Vendor on behalf of the Contractor a survey benefit amount, to be determined by the State based upon plan enrollment and survey milestones, which determine the number of families to be surveyed.

6. The Contractor agrees to provide the State with a camera-ready and electronic copy of the Contractor's logo, a signature of a high level Contractor official and sample pieces of the Contractor's stationary and envelopes. The State assures the Contractor that the items listed in this section shall only be used in the conduct of the CAHPS® and YAHCS Surveys.

C. Standards Designed to Improve the Quality of Care

1. The Contractor assures the State that its providers shall use, and the Contractor shall monitor, the most recent recommendations of the American Academy of Pediatrics (AAP) with regard to Recommendations For Preventative Pediatric Health Care and the most recent version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

2. The Contractor agrees to notify the applicants associated with all subscriber children enrolled in Contractor's plan through the Program, on an annual basis, of the recommended schedule of preventive care visits. The first notice shall be included in the materials provided by the Contractor to new members pursuant to Item II.F.1. Such notification shall be provided via a mailed notice or brochure and shall be provided in English and Spanish. The Contractor agrees that, as soon as more than five percent (5%) of subscribers enrolled with the Contractor or 3,000 subscribers enrolled with the Contractor in the Program are identified as primarily speaking a language other than English or Spanish, the Contractor shall provide the notice in such language.

3. The Contractor shall increase the awareness among its providers of the importance of screening for overweight and obese children using such measures as Body Mass Index. The Contractor shall also increase the awareness among applicants and subscribers of the health risks associated with being overweight and obese, as well as the importance of good nutrition and physical activity. The Contractor shall report to the State by December 10 of each year on current and planned activities to comply with these requirements.

D. Quality Management Processes

1. The Contractor assures the State that the Contractor shall maintain a system of accountability for quality improvement activities which includes the participation of the governing body of the Contractor's organization, the designation of a Quality Improvement Committee,

supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of Quality Improvement development and performance. Evidence of such activities shall be provided to the State upon request.

2. The Contractor represents that its Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), or the California Department of Managed Health Care.

3. The State intends to track the Contractor's performance on the measures that are listed in Item V.A.1. The State's analysis of the Contractor's performance shall include, but not be limited to, the Contractor's performance for the most recent reporting period, a comparison of the Contractor's performance over two reporting periods, and a comparison of the Contractor's performance with national benchmarks. The Contractor agrees to submit a corrective action plan for performance upon request by the State.

4. The Contractor understands that the State may implement a pay-for-performance system for plans participating in the Program beginning in the 2006-07 contract year. Details of the pay-for-performance system will be developed with input from participating plans. During the 2005-06 contract year, the State shall give Contractor an opportunity to participate in a work group to determine the specific terms and conditions for payment, as well as the feasibility of such a program. Specific terms and conditions shall be implemented via an amendment to this Agreement.

E. <u>Ongoing Efforts To Improve Quality Measures And Accountability</u>

1. The State intends to convene a Healthy Families Quality Reporting Work Group. The Contractor agrees to participate in the Work Group. The purpose of the Work Group is to discuss technical issues regarding the provision of quality related reports as outlined in Item V.A of this Exhibit. The Work Group will also provide input on other quality activities undertaken by the State to measure the quality of care provided to Program subscribers and the utilization of services through the collection of claims and encounter data.

2. The Work Group shall meet periodically beginning in the fall of 2005 and shall be tasked with developing recommendations for implementing the Program's clinical quality improvement strategy.

The Program's clinical quality improvement strategy may include activities to evaluate and address health disparities among language and ethnic groups and implementation of non-monetary rewards to plans for performance, including the use of performance thresholds.

EXHIBIT B

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EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

I. PAYMENT PROVISIONS

The Contractor agrees to arrange for the provision of medical benefits and case management services for subscribers in the Program as described in Exhibit A, Section IV. of this Agreement.

A Fees Provided to Contractor

1. As specified in Item I.B. of this Exhibit, the State shall pay the Contractor a flat fee per month per subscriber child of the age of one and over for all services received by the subscriber and a flat fee per month per subscriber child who is enrolled in the program under the age of one for all services received by the subscriber (infant rate). For a subscriber child who is enrolled in the program under the age of one, the State will pay the infant rate through the end of the month of the child's first birthday, but for no more that twelve (12) months. A subscriber's age will be determined on the first day of each month except as further provided herein. For a child who is enrolled in the program on or after the child's first birthday, the State shall pay at the rate for children age one and over, in accordance with Item I.B.1. of this Exhibit . These fees are set forth in Attachment VI, Confidential Rates of Payment, which is hereby incorporated.

2. In cases of subscriber eligibility and enrollment appeals, which results in liability of health care costs by the State, the Contractor shall pay the provider for services delivered within 30 days following notification by the State of the appeal findings and shall claim reimbursement from the State within 45 days after notification by the State of the appeal findings. The State shall pay the Contractor the actual costs paid by the Contractor for services received. The Contractor shall reimburse and claim for such services at any discounted rate that the Contractor may have in place for the provider in the program and that is accepted by the provider as payment in full. Such payments may only be made by the Contractor and paid by the State when the Contractor receives prior written direction from the State.

3. (ONLY FOR HEALTH PLANS THAT ARE ALSO AIM CONTRACTORS)

Notwithstanding Item I.A.1., the State shall pay the Contractor a lump sum payment to cover an infant born to a woman enrolled in the AIM Program with the Contractor. The payment shall cover the period from birth through the end of the month following the month of birth. The State shall make the lump sum payment in the month following the reporting of the birth by the Contractor to the Administrative Vendor for the HFP/AIM programs, for only those infants who have been reported to the Administrative Vendor in accordance with the provisions in Exhibit A, Item II.B. After the second month, if the infant remains enrolled with the Contractor, the State shall pay the Contractor at the infant rate specified in Item I.A.1 through the end of the month of the Child's first birthday, but for no more than ten (10) months. The lump sum fee is set forth in Attachment VI, Confidential Rates of Payment. Infants who were not reported by the Contractor in accordance with Exhibit A, Item II.B shall be paid at the infant rate specified in Item I.A.1 upon enrollment, pursuant to Item I.B..

B. Payment Schedule

1. For the first month or partial month of a subscriber's coverage the State agrees to pay one hundred percent (100%) of the fee described in Item I.A.1. of this Exhibit for subscribers with effective dates of coverage on the first (1st) through fifteenth (15th) day of the month. No fee shall be paid for the first partial month of coverage for subscribers whose coverage begins on the sixteenth (16th) through thirty-first (31st) day of the month. The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.

2. For all months of coverage after the first month in which a subscriber's coverage becomes effective, the State agrees to pay the fee described in Item I.A.1. of this Exhibit. The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.

C. Special Enrollment Materials Cost

In any event of an early termination or the removal of coverage in a service area by the Contractor which requires a special open enrollment, the Contractor agrees to pay the State $9.00 per applicant for subscribers enrolled in the Contractor's plan who must be moved to another participating plan.

II. FISCAL CONTROL PROVISIONS

A. Minimum Loss Ratio

1. The Contractor agrees that administrative costs shall be reasonable. The Contractor agrees that, once the Contractor's plan has a minimum of 1,000 enrolled subscribers per month for six or more months of a benefit year, the minimum loss ratio for services provided to all subscribers pursuant to this Agreement shall be 85%. For reporting purposes, the Contractor's loss ratio shall be calculated in aggregate for all subscribers, using the following formula:

   a/b

   Where "a" is :Total covered benefit and service costs of Contractor including incurred but not reported claim completion costs minus subscriber copayment requirements and minus amounts recovered pursuant to Exhibit A, Items IV.I, IV.J. and IV.K. of this Agreement, and

   where "b" is : Total premiums received by the Contractor.

2. The Contractor shall report the previous benefit year's loss ratio by January 1 of each year.

3. The Contractor understands that the State may make the results of the loss ratio report listed in Item 2. above available to the public.

B. Payment Limitation

1. Only subscribers for whom a premium is paid by the State to the Contractor are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the subscriber is enrolled.

2. The Contractor agrees to reconcile, on at least a monthly basis, eligibility data provided by the State with the Contractor's data on persons for whom claims, capitation payments, and other payments related to services and benefits were made in the Program. The Contractor shall make any necessary adjustments indicated by the reconciliation to ensure compliance with Item II.B.1. The Contractor shall maintain records of these reconciliations in accordance with Exhibit D, Item II.C. of this Agreement. The Contractor shall ensure that only the costs of services and benefits

covered in the Program are included in the numerator of the loss ratio calculation set forth in Item II.A.

3. The State shall not be liable for any reconciliation discrepancies reported by the Contractor more than sixty (60) days from the date the monthly audit file is provided to the Contractor, pursuant to Exhibit A, Item II.J.8.

C. Availability of Federal Funds

1. It is mutually understood between the parties that this Agreement may have been written for the mutual benefit of both parties, before ascertaining the availability of Congressional appropriation of funds, to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

2. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purposes of this program for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or to any statute enacted by the Congress that may affect the provisions, terms or funding of this Agreement in any manner.

3. The parties mutually agree that, if Congress does not appropriate sufficient funds for the Program, this Agreement shall be amended to reflect any reduction in funds.

4. The State has the option to invalidate this Agreement under the 30 day termination clause in Exhibit D, Item I.B. or to amend the Agreement to reflect any reduction in funds.

D. Prior to Fiscal Year/Crossing Fiscal Years

It is mutually agreed between the parties that this Agreement may have been signed and executed prior to the start of the 2005-06 State Fiscal Year, before ascertaining the availability of funds for the 2005-06 State Fiscal Year. This Agreement has also been written with a term that crosses State Fiscal Years, and therefore before ascertaining the availability of legislative appropriation of funds for the 2006-07 and 2007-08 State Fiscal Years. This Agreement is valid and enforceable only if sufficient funds are made available through the 2006-07 and 2007-08 State Budgets for the purposes of this Program. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted in statute by the State Legislature which may affect the provision, term or funding of this Agreement in any manner. It is mutually

agreed that if the State Legislature does not appropriate sufficient funds for this Program, the Agreement shall be amended to reflect any reduction in funds and enrollment shall be curtailed by the State proportionately.

E. Healthy Families Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the Healthy Families Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Items I.A. and I.B. of this Exhibit.

F. Fiscal Solvency **(DMHC)**

The Contractor agrees that it shall at all times maintain the reserves required under the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated there under by the Department of Managed Health Care, including the Tangible Net Equity regulations.

Evidence of above solvency shall be made available to the State upon request.

OR

F. Fiscal Solvency **(DOI)**

The Contractor agrees that it shall at all times comply with all solvency requirements of its licensing statute and regulations and shall at all times maintain one of the following:

a. A rating of A+ under Best insurance rating, or

b. A surplus capable of paying one month of Contractor's paid claims. The amount of one month of the Contractor's paid claims shall be established by averaging claims paid in each of the previous twelve (12) months.

Evidence of above solvency shall be made available to the State upon request.

G. Federally Funded Programs (Medicare & Medicaid)

The Contractor shall remain in good standing with the State Department of Health Services for services provided to Medi-Cal subscribers, with the federal Centers for Medicare and Medicaid Services for services provided to Medi-Cal or Medicare subscribers, and with the Office of the Inspector

General of the Department of Health and Human Services. On request, the Contractor agrees to provide the State immediately with copies of all correspondence received from the Department of Health Services, the Centers for Medicare and Medicaid Services, and the Office of the Inspector General of the Department of Health and Human Services which pertains to the Contractor's standing with the respective departments. In addition, the Contractor shall immediately notify the State of any investigations in which there are allegations related to fraud, including but not limited to: 1) the receipt of an administrative subpoena from any state or federal agency, unless the Contractor is advised that it is not the target or subject of the investigation; 2) the receipt of a grand jury subpoena from any state or federal court, unless the contractor is advised that it is not the target or subject of the investigation; 3) the execution of a search and seizure warrant at any of the contractor's offices or locations related to such investigations; and 4) the filing of any charges against the contractor in any state or federal court related to such investigations. The Contractor shall immediately notify the State if the Contractor receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the State Department of Health Services, the Centers for Medicare and Medicaid Services, or the Office of the Inspector General of the Department of Health and Human Services.

H. Licensing Sanction Notifications **(DMHC)**

The Contractor agrees that it shall remain in good standing with the Department of Managed Health Care. On request, the Contractor agrees to provide the State with copies of all correspondence from the Department of Managed Health Care that pertains to the Contractor's standing with its regulatory entity. The Contractor shall immediately notify the State if the Contractor receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the Department of Managed Health Care.

OR

H. Licensing Sanction Notifications **(DOI)**

The Contractor agrees that it shall remain in good standing with the Department of Insurance. The Contractor agrees to provide the State with copies of all correspondence from the Department of Insurance that pertains to the Contractor's standing with their regulatory entity. The Contractor shall immediately notify the State if the Contractor receives a letter of pending significant sanction or corrective action from the Department of Insurance.

I. Contractor Performance Standards, Liquidated Damages and Remedy for Non-Performance

1. The State shall monitor the Contractor's compliance with the terms of this Agreement. The State shall attempt to work with the Contractor to assist the Contractor in fulfilling its obligations under this Agreement.

2. If the State finds the Contractor to be out of compliance with the terms of the Agreement, the State may, after thirty (30) days written notice to the Contractor and an opportunity to cure such non-compliance or default within that thirty (30) day period, suspend thereafter enrollment of eligible subscribers in the Contractor's health plan. Notice provided to the Contractor pursuant to this section shall include a description of those actions/standards the Contractor must achieve for enrollment to be resumed. Resumption of enrollment is at the discretion of the State.

3. The State and the Contractor agree that the following sections of this Agreement contain objective performance standards to be met by the Contractor which shall be monitored by the State:

   a. Exhibit A, Item II.F. Identification Cards, Provider Directory, and Evidence of Coverage or Certificate of Insurance Booklet

   b. Exhibit A, Item II. K. Network Information Service

   c. Exhibit A, Item II. L.2. and 3. Traditional and Safety Net Providers Reports

   d. Exhibit A, Item III. A. Telephone Service for Subscribers

   e. Exhibit A, Item III.B.2. Grievance Report

   f. Exhibit A, Item III.C.4.c. Cultural and Linguistic Services Report

   g. Exhibit A, Item IV.B.3. California Children's Services Report

   h. Exhibit A, Item IV.D.3. Mental Health: Services for Subscribers with Serious Emotional Disturbance Report

   i. Exhibit A, Item IV.H.3. Copayments Report

   j. Exhibit A, Item V.A. Measuring Clinical Quality

k. Exhibit A, Item V.B.. Measuring Consumer Satisfaction

l. Exhibit A, Item V.C.. Standards Designed to Improve the Quality of Care

m. Exhibit B, Item I.C. Special Enrollment Materials Cost

n. Exhibit B, Item II.A.2. Minimum Loss Ratio Report

o. Exhibit B, Item II.B.2. Payment Limitation Reconciliation

4. If, in the State's view, the Contractor has not fulfilled its contractual responsibilities with regard to one or more of the items identified in Item 3. above, the State shall notify the Contractor in writing of the Contractor's lack of performance. If the Contractor does not improve performance to an acceptable level within 5 business days after receipt of such notice, the State may impose liquidated damages on the Contractor of no more than five percent (5%) per day of the Contractor's average daily fee per day beginning on the sixth business day following notification. If the Contractor's performance does not improve within 15 additional business days from the first day liquidated damages were imposed, the State after written notice to the Contractor, may increase the liquidated damages to ten percent (10%) per day of the Contractor's average daily fee per day beginning on the 16th business day following the receipt of notification of non-performance until the Contractor is in compliance with the Contract. The Contractor's average daily fee is calculated by taking the Contractor's total monthly premium and dividing by the number of calendar days in that particular month. In no event shall the total amount of liquidated damages imposed for the items identified in Item 3. above exceed ten percent (10%) per day.

5. All liquidated damages must be paid to the State within ten (10) calendar days of receipt of an assessment letter.

6. If the State determines that the Contractor's non-performance was caused in whole or in part by the State, the State shall reduce the damages proportionately.

7. The parties agree that the damages for failure to provide the deliverables and/or meet the contractual performance standards described herein are not susceptible to exact calculation in advance and that the liquidated damage amounts specified in this Agreement represent an agreed estimate of what the future

damages would be. These liquidated damages are not intended to be penalties.

J. Licensure **(DMHC)**

Department of Managed Health Care Licensees

The Contractor assures the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Managed Health Care.

OR

J. Licensure **(DOI)**

Department of Insurance Licensees:

The Contractor assures the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Insurance.

K. Risk Assessment and Adjustment Process

The State may convene a Risk Assessment/Risk Adjustment Work Group for the purpose of exploring the necessity and feasibility of assessing and correcting for risk mix differences between health plans. The Contractor agrees to provide technical staff to participate in the Work Group to be convened by the State.

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EXHIBIT C
GENERAL TERMS AND CONDITIONS

I. APPROVAL

This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. The Contractor may not commence performance until such approval has been obtained.

II. AMENDMENT

No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

III. ASSIGNMENT

This Agreement is not assignable by the Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

IV. AUDIT

Contractor agrees that the awarding department ("the State") and the Bureau of State Audits, or their designated representatives, shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Contractor agrees to include the same right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, PCC 10115 et seq., CCR Title 2, Section 1896).

V. INDEMNIFICATION

Contractor agrees to indemnify, defend and save harmless the State, its officers, trustees, agents and employees (the "indemnitees") from any and all claims, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorneys' fees, which (i) arise out of, are due to, or are alleged to arise out of or be due to, or are alleged to arise out of or be due to, a breach by the Contractor of any of its representations, warranties, covenants or other obligations contained in this Agreement, or (ii) are caused by or result from or are alleged to arise out of or result from, the Contractor's acts or omissions constituting bad faith, willful misfeasance, negligence or reckless disregard of its duties under this

Agreement, or (iii) accrue or result, or are alleged to accrue or result, to any and all contractors, subcontractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Agreement.

The Contractor shall also indemnify, defend and hold harmless the indemnitees from and against any and all losses (as described in paragraph one of this Item) that result or are alleged to result from the failure to provide, or the negligent provision of, medical or other services or supplies by the Contractor, its independent subcontractors or agents. The State agrees to notify the Contractor in writing promptly of any such claims and to assist the Contractor (at Contractor's expense) in the defense of same.

If and to the extent that the Contractor has knowledge of a claim that it believes may develop into an action that would be subject to this Agreement, the Contractor shall promptly notify the State of the claim.

VI. DISPUTES

Contractor shall continue with the responsibilities under this Agreement during any dispute, unless directed otherwise by the State in writing.

VII. TERMINATION FOR CAUSE

The State may terminate this Agreement and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. Such right of termination shall be without prejudice to any other remedies available to the State. Upon receipt of any notice terminating this Agreement, the Contractor shall immediately discontinue all activities affected, unless the notice directs otherwise, and the State may proceed with the work in any manner deemed proper by the State. In such event, the State shall pay the Contractor only the reasonable value of the services rendered, and all costs to the State shall be deducted from any sum due the Contractor. The State may, at its sole discretion, offer an opportunity to cure any breach prior to terminating for default.

VIII. INDEPENDENT CONTRACTOR

The Contractor, and the agents and employees of the Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State except for purposes of Civil Code Section 1798.24.

IX. RECYCLING CERTIFICATION

The Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of recycled content, both post consumer waste and secondary waste as defined in the Public Contract Code, Sections 12161 and 12200, in materials, goods, or supplies offered or products used in the performance of this Agreement, regardless of whether the product meets the required recycled product percentage as defined in the Public Contract Code, Sections 12161 and 12200. Contractor may certify that the product contains zero recycled content. (PCC 10233, 10308.5, 10354)

X. NON-DISCRIMINATION CLAUSE

During the performance of this Agreement, Contractor and its subcontractors, as well as their agents and employees, shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (over 40), marital status, and use of family and medical care leave pursuant to state or federal law. Contractor and subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. Contractor and subcontractors, as well as their agents and employees, shall ensure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. The Contractor and subcontractors, as well as their agents and employees, shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2, California Code of Regulations, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under the Agreement.

XI. CONTRACTOR CERTIFICATION CLAUSES

A. Statement of Compliance

Contractor has, unless exempted, complied with the nondiscrimination program requirements. (GC 12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)

B. Drug-free Workplace Requirements.

Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

1. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

2. Establish a Drug-Free Awareness Program to inform employees about:

    a. the dangers of drug abuse in the workplace;

    b. the person's or organization's policy of maintaining a drug-free workplace;

    c. any available counseling, rehabilitation and employee assistance programs; and,

    d. penalties that may be imposed upon employees for drug abuse violations.

3. Every employee who works on the proposed Agreement will:

    a. receive a copy of the company's drug-free workplace policy statement; and

    b. agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the State determines that any of the following has occurred: (1) the

Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (GC 8350 et seq.)

C. National Labor Relations Board Certification

Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court which orders Contractor to comply with an order of the National Labor Relations Board. (PCC 10296) (Not applicable to public entities.)

D. Union Organizing

Contractor hereby certifies that no request for reimbursement, or payment under this agreement, will seek reimbursement for costs incurred to assist, promote or deter union organizing.

E. Expatriate Corporations

The Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

F. Sweat-free Code of Conduct

1. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweat-free Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

2. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

G. Domestic Partners

Commencing on July 1, 2004, the Contractor certifies that it is in compliance with Public Contract Code section 10295.3 with regard to benefits for domestic partners. For any contracts executed or amended, bid packages advertised or made available, or sealed bids received on or after July 1, 2004 and prior to January 1, 2007, a contractor may require an employee to pay the costs of providing additional benefits that are offered to comply with PCC 10295.3.

H. Doing Business with the State of California

1. Conflict of interest

Contractor acknowledges the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement the Contractor shall contact the State immediately for clarification.

a. Current State Employees (PCC 10410):

(1) No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

(2) No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

b. Former State Employees (PCC 10411):

(1) For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged

in any of the negotiations, transaction, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

(2) For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

c. If Contractor violates any provisions of the above paragraphs, such action by Contractor shall render this Agreement void. (PCC 10420).

d. Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (PCC 10430 (e)).

2. Labor Code/Workers' Compensation.

Contractor acknowledges the provisions of law which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor agrees to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700.)

3. Americans with Disabilities Act

Contractor certifies that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. Contractor Name Change

Contractor acknowledges that an amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. Corporate Qualifications to do Business in California

   a. Contractor acknowledges that, when agreements are to be performed in the state by corporations, the State will verify that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

   b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

   c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. Resolution

   A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. Air or Water Pollution Violation

   Contractor acknowledges that, under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation or provisions of federal law relating to air or water pollution.

8. Payee Data Record Form Std 204

   Contractor acknowledges that this form must be completed by all contractors that are not another state agency or other government entity.

XII. TIMELINESS

Time is of the essence in this Agreement.

XIII. COMPENSATION

The consideration to be paid Contractor, as provided herein, shall be in compensation for all of Contractor's expenses incurred in the performance hereof, including travel, per diem, and taxes, unless otherwise expressly so provided.

XIV. GOVERNING LAW.

This Agreement shall be administered, construed, and enforced according to the laws of the State of California (without regard to any conflict of laws provisions) to the extent such laws have not been preempted by applicable federal law. Any suit brought hereunder (including any action to compel arbitration or to enforce any award or judgment rendered thereby) shall be brought in the state or federal courts sitting in Sacramento, California, the parties hereby waiving any claim or defense that such forum is not convenient or proper. Each party agrees that any such court shall have in personam jurisdiction over it and consents to service of process in any manner authorized by California law.

XV. ANTITRUST CLAIMS

The Contractor by signing this agreement hereby certifies that if these services or goods are obtained by means of a competitive bid, the Contractor shall comply with the requirements of the Government Codes sections set out below.

A. The Government Code Chapter on Antitrust claims contains the following definitions:

1. "Public purchase" means a purchase by means of competitive bids of goods, services, or materials by the State or any of its political subdivisions or public agencies on whose behalf the Attorney General may bring an action pursuant to subdivision (c) of Section 16750 of the Business and Professions Code.

2. "Public purchasing body" means the State or the subdivision or agency making a public purchase. Government Code Section 4550.

B. In submitting a bid to a public purchasing body, the bidder offers and agrees that if the bid is accepted, it will assign to the purchasing body all rights, title, and interest in and to all causes of action it may have under Section 4 of the Clayton Act (15 U.S.C. Sec. 15) or under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of

the Business and Professions Code), arising from purchases of goods, materials, or services by the bidder for sale to the purchasing body pursuant to the bid. Such assignment shall be made and become effective at the time the purchasing body tenders final payment to the bidder. Government Code Section 4552.

C. If an awarding body or public purchasing body receives, either through judgment or settlement, a monetary recovery for a cause of action assigned under this chapter, the assignor shall be entitled to receive reimbursement for actual legal costs incurred and may, upon demand, recover from the public body any portion of the recovery, including treble damages, attributable to overcharges that were paid by the assignor but were not paid by the public body as part of the bid price, less the expenses incurred in obtaining that portion of the recovery. Government Code Section 4553.

D. Upon demand in writing by the assignor, the assignee shall, within one year from such demand, reassign the cause of action assigned under this part if the assignor has been or may have been injured by the violation of law for which the cause of action arose and (a) the assignee has not been injured thereby, or (b) the assignee declines to file a court action for the cause of action. See Government Code Section 4554.

XVI. CHILD SUPPORT COMPLIANCE ACT

In accordance with the Child Support Compliance Act,

A. The contractor acknowledges the importance of child and family support obligations and shall fully comply with all applicable state and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code; and

B. The Contractor certifies that it is, to the best of its knowledge, fully complying with the earnings assignment orders of all employees and is providing the names of all new employees to the New Hire Registry maintained by the California Employment Development Department.

XVII. UNENFORCEABLE PROVISION

In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

XVIII. UNION ACTIVITIES

By signing this Agreement, Contractor hereby acknowledges the applicability of Government Code Section 16645 through Section 16649 to this Agreement and agrees to the following:

A. Contractor will not assist, promote or deter union organizing by employees performing work on a state service contract, including a public works contract.

B. No state funds received under this agreement will be used to assist, promote or deter union organizing.

C. Contractor will not, for any business conducted under this agreement, use any state property to hold meetings with employees or supervisors, if the purpose of such meetings is to assist, promote or deter union organizing, unless the state property is equally available to the general public for holding meetings.

D. If Contractor incurs costs, or makes expenditures to assist, promote or deter union organizing, Contractor will maintain records sufficient to show that no reimbursement from state funds has been sought for these costs, and that Contractor shall provide those records to the Attorney General upon request.

E. Contractor will be liable to the State for the amount of any funds expended in violation of the requirements of Government Code section 16645.4, plus a civil penalty equal to twice the amount of those funds.

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EXHIBIT D
SPECIAL TERMS AND CONDITIONS

I. TERMINATION

A. Annual Termination

Contractor may terminate this Agreement on an annual basis without cause by giving written notice of termination to the State no later than five months before the beginning of the next plan year for the Program. The effective date of any termination pursuant to this section shall be the first day of the next plan year.

B. Termination for Convenience

1. In addition to the State's right to terminate pursuant to Exhibit C, Section VII and as otherwise provided in this Agreement., the State may terminate this Agreement without cause by giving written notice of termination to the Contractor not less than thirty (30) calendar days prior to the effective date of the termination. In the event the State terminates all or a portion of this Agreement pursuant to this Item I.B., it is understood that the State shall pay the Contractor for satisfactory services rendered prior to the termination, but not in excess of the amount payable pursuant to the terms of this Agreement or in excess of the maximum contract amount.

2. If, after notice of termination for failure to fulfill contract obligations pursuant to Exhibit C, Item VII, it is determined that Contractor had not so failed, the termination shall be deemed to have been effected for the convenience of the State pursuant to this Item I.B.

C. Termination for Insolvency

Contractor shall notify the State immediately in writing in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudged bankrupt, or a receiver is appointed and qualifies. In the event of any of the foregoing events, or if the State determines, based on reliable information, that there is a substantial probability that Controller will be financially unable to continue performance under this Agreement, the State may terminate this Agreement and all further rights and obligations immediately by giving five (5) days' notice in writing.

D. Responsibilities of the Parties

Upon notice of termination on any basis under this Agreement the responsibilities of the parties shall be as follows:

1. Upon receipt of any notice terminating this Agreement, the Contractor shall immediately discontinue all services affected, unless the notice directs otherwise.

2. New enrollments by the Contractor shall cease on a date to be determined by the State.

E. Assurances Upon Termination

Upon the termination of this Agreement, the Contractor shall cooperate fully with the State in order to effect an orderly transition of subscribers to another health care plan. This cooperation shall include, without limitation, attending such post-termination meetings as shall be reasonably requested by the State.

II. AFFIRMATIVE COVENANTS

A. Notice of Proceedings

The Contractor shall promptly notify the State in writing of any investigation, examination or other proceeding involving the Contractor, or any Key Personnel, commenced by any regulatory agency which proceeding is not conducted in the ordinary course of the Contractor's business.

B. Maintenance of Insurance

1. The Contractor warrants that it carries adequate directors and officers liability insurance, workers' compensation insurance, employer liability insurance and other insurance as specified by the State, and that it shall maintain such insurance at levels acceptable to the State in full force and effect during the term of this Agreement. All insurance shall be adequate to provide coverage against losses and liabilities attributable to the acts or omissions of the Contractor in performance of this Agreement and to otherwise protect and maintain the resources necessary to fulfill the Contractor's obligations under this Agreement. The Contractor shall maintain additional insurance coverage for business interruption and data processing coverage arising from significant system problems. Satisfactory evidence of all coverage shall be made available to the State upon request.

2. Contractor warrants that Contractor's participating physicians are insured for malpractice, either independently or through Contractor, in a dollar amount sufficient for their practice. Contractor's participating providers also have liability insurance in a dollar amount appropriate for their business practice.

C. Books and Records

The Contractor shall keep accurate books and records connected with the performance of this Agreement during and for three years after the term of this Agreement, or until the final payment under this Agreement, whichever is later. Such books and records shall be kept in a secure location at the Contractor's office(s). If an audit, review, examination or evaluation is commenced during the time specified herein for the maintenance of books and records, Contractor shall continue to maintain all relevant books and records until the audit, review, examination or evaluation is completed. The Contractor shall ensure that books and records of subcontractors, suppliers, and other providers shall also be accurately maintained for the same periods.

D. Quality and Financial Audits

1. During and for three years after the term of this Agreement, or until the final payment under this Agreement, whichever is later, the Contractor agrees that the State, its authorized representatives, and such consultants and specialists as needed, as well as the State Auditor, or their representatives, consultants, and specialists shall have the right to review, obtain, and copy all records pertaining to performance of the contract. The Contractor agrees to provide the applicable state agencies or their representatives, consultants, and specialists with any requested information connected with performance of this Agreement and shall permit the agencies or their representatives, consultants, and specialists access to its premises, upon reasonable notice, during normal business hours for the purpose of interviewing employees and inspecting and copying such books, records, accounts, and other material that may be relevant to a matter under investigation. If an audit, review, examination or evaluation is commenced during the time specified herein, Contractor shall continue to provide access as specified above until the audit, review, examination or evaluation is completed.

2. The Contractor shall comply with the caveats and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code Section 10110.10.

3. The Contractor shall submit to the State a copy of its annual Certified Public Accountant (CPA) report (balance sheet, income statement, cash flow statement and related notes to the financial statements, as well as the management letter). The Contractor shall submit the CPA report to the State within thirty (30) calendar days of its receipt. The Contractor shall also report to the State as applicable, its corrective action plan in any audit findings specifically related to the duties and responsibilities under this agreement. The Contractor agrees to submit quarterly unaudited financial statements (balance sheet and income statements) to the State, if such statements are requested by the State.

4. The State may make periodic audits and reviews, examinations or evaluations at its expense regarding the Contractor's performance under this Agreement, including but not limited to the quality of services rendered pursuant to this Agreement. The State may also audit and examine records and accounts, which pertain, directly or indirectly, to the Contractor (including its parent corporation). The Contractor shall cooperate fully with such auditors; however, such audit shall not interfere with the administration of the Contract, or with the administration of the Contractor.

5. Audits, reviews, examinations or evaluations may be undertaken directly by the State, or by the Office of the State Auditor, or by third parties engaged by the State, including accountants, consultants and physicians. The Contractor shall cooperate fully with the State or any such third party in connection with such audit, review, examination or evaluation.

6 All adjustments, payments and/or reimbursements determined to be necessary by any audit, review, examination or evaluation shall be made promptly by the appropriate party.

7. The Contractor shall have the opportunity, prior to the release of the audit, review, examination, or evaluation report, to review the draft and to include in the report its responses to issues raised by the report.

E. Contractor Cooperation

The State has agreements with an administrative vendor, other participating health plans and other contractors and consultants for the purpose of implementing and maintaining the Program. The Contractor shall cooperate fully, and in a timely manner with the State and any of the

State's other contractors involved in implementing and maintaining the Program.

F. Copyright Protections

The Contractor agrees to grant to the State a royalty-free, nonexclusive and irrevocable license to publish, translate, reproduce, deliver, perform, dispose of and authorize others to do so, all data, electronic data processing software that is specifically developed exclusively for this contract, and all Program forms and public informational materials, which are covered by copyright and were specifically developed by the Contractor for the implementation of this Agreement. Such license shall be effective only to the extent that the Contractor has the right to grant such license without becoming liable to pay compensation to others because of such grant.

G. Subcontractors

The Contractor shall obtain prior written approval from the state before subcontracting any of the services delivered under this Agreement unless approval of the subcontract is included in this Agreement. Any subcontracting shall be subject to applicable provisions of this contract, and all applicable State and Federal regulations. The Contractor shall be held responsible by the State for the performance of any subcontractor.

H. Notices

The parties agree that to avoid unreasonable delay in the progress of the services performed hereunder, the Contractor and the State shall each designate specific staff representatives for the purpose of communication between the parties. Any notice or other written communication required or which may be given hereunder shall be deemed given when delivered personally, or if mailed, three (3) days after the date of mailing; unless by express mail, facsimile telecopy, or telegraph, then upon the date of confirmed receipt, to the following representatives:

For the State:

Managed Risk Medical Insurance Board
Attn: Joyce Iseri, Chief Deputy Director
1000 G Street, Suite 450
Sacramento, CA 95814
Telephone No.: (916) 324-4695
Fax No. (916) 324-4878

For Contractor:
Health Plan
Attn: Name
****
****
Telephone No. (***) ***-***
Fax No. (***) ***-****

Either party hereto may, from time to time by notice in writing served upon the other as aforesaid, designate a different mailing address or a different or additional person to which all such notices or demands thereafter are to be addressed.

I. Permits and Licenses

The Contractor shall procure and keep in full force and effect during the term of this Agreement all permits and licenses necessary to accomplish the work contemplated in this Agreement.

J. Compliance with Applicable Law

The Contractor shall carry out its duties and responsibilities herein in accordance with, be limited in the exercise of its rights by, and observe and comply with, all federal, state, city and county law, including but not limited to statutes, ordinances, rules and regulations, and common law affecting services under this Agreement.

K. Reports and/or Meetings

1. The Contractor shall provide oral or written progress reports as requested by the State to determine if the Contractor is performing to expectations or is on schedule, to provide communication of interim findings, and to afford occasions for discussing and resolving problems encountered.

2. The Contractor shall meet with the State upon request to discuss progress on the Agreement or to present findings, conclusions and recommendations.

L. Additional Documents

The Contractor and the State agree to execute such additional documents, and perform such further acts, as may be reasonable and necessary to carry out the provisions of this Agreement.

M. Changes in Control Organization

The Contractor shall promptly, and in any case within five (5) calendar days, notify the State in writing: (i) if any of the Contractor's representations and warranties, as set forth in this Agreement, cease to be true at any time during the term of this Agreement; (ii) of any change in the Contractor's staff who exercise a significant administrative, policy, or consulting role under this Agreement; (iii) of any change in the majority ownership, control, or business structure of the Contractor; or (iv) of any other material change in the Contractor's business, partnership or corporate organization. All written notices from the Contractor under this provision shall contain sufficient information to permit the State to evaluate the changes within the Contractor's personnel or organization under the same criteria as was used by the State in its award of this Agreement to the Contractor. The Contractor agrees to promptly provide the State with such additional information as the State may request.

N. Confidentiality

1. The Contractor agrees to protect the security and confidentiality of all eligibility and enrollment data and all other personal information and protected health information about individuals maintained as part of each Program in accordance with the Information Practices Act, Civil Code Section 1798 et seq., and all other applicable State and Federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations promulgated thereunder. All financial, statistical, personal, technical and other data and information relating to the State operations which are designated confidential by the State which become available to the Contractor shall be protected by the Contractor from unauthorized use and disclosure.

2 All financial, statistical, personal, technical and other data and information relating to the State’s operation which are designated confidential by the State and which become available to the Contractor shall be protected by Contractor from unauthorized use and disclosure.

3. The Contractor agrees that it shall not use any individual identifiable information or other confidential information for any purpose other than carrying out the provisions of this Agreement.

4. The Contractor shall ensure that all of its officers, employees, representatives, consultants, subcontractors, or agents who have access to any confidential information for purposes of carrying out the provisions of this Agreement shall execute a confidentiality

agreement incorporating all requirements of this Item II.N. in a form acceptable to the State.

O. HIPAA Compliance

The State and Contractor recognize that, as regulations are promulgated and become effective under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the State may add one or more additional provisions to this Agreement in order for the State to achieve compliance with all applicable HIPAA requirements. The State may, by written notice to Contractor, amend this Agreement to comply with such new regulations. If Contractor agrees with any such amendment, it shall so notify the State in writing within thirty (30) days of the written notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, the State may terminate this Agreement for cause as provided in Exhibit C, Section VII.

P. Disclosure of Contractor Records and Rates of Payment

1. As authorized by Section 6254 of the Government Code, the State and the Contractor shall protect from public disclosure all program records related to the deliberative process, discussions, communications or negotiations over the development of this Agreement.

2. This Agreement and its terms shall remain confidential to the full extent permitted by applicable law, including Government Code Section 6254. For the purposes of this Agreement, disclosure shall be as follows:

   a. This Agreement and any subsequent amendments, with the exception of Attachment VI, Confidential Rates of Payment, shall not be open to public inspection and shall be kept confidential until one year after the effective starting date of this Agreement or amendment, as applicable, except as required by law.

   b. The rates of payment for this Agreement as contained in Attachment VI, Confidential Rates of Payment, shall not be open to public inspection and shall be kept confidential until four years after the effective starting date of this Agreement. All documents and reports held by the State which refer to rates of payment shall also be kept from public inspection until four years after this Agreement has been fully executed.

c. Any rates of payment for this Agreement added through a contract amendment and as contained in Attachment VI, Confidential Rates of Payment, shall not be open to public inspection and shall be kept confidential until four years after the effective date of the added rates. All documents and reports held by the State which refer to rates of payment as amended shall also be kept from public inspection until four years after the effective date of the added rates.

d. The entire Agreement, or amendments to this Agreement, or other records pertaining to the rate of payment, shall be open to inspection by the Joint Legislative Audit Committee and its authorized auditors.

e. The records pertaining to the rate of payment, shall be open to federal auditing authorized by the Department of Health and Human Services or the United States Comptroller General and their authorized representatives.

f. As needed, the State shall also allow its own authorized auditors and contractors, including actuarial consultants, whether public or private, to have access to the Agreement, its amendments, the payment rates, and records containing payment rates. The State shall bind its auditors and contractors to the confidentiality requirements contained in this Agreement.

III. NEGATIVE COVENANTS

A. Conflict of Interest

1. The Contractor shall not directly or indirectly receive any benefit from recommendations made to the State and shall disclose to the State any investment or economic interest of the Contractor, or the Contractor's personnel performing services under this Agreement, which may be enhanced by the recommendations made to the State. The Contractor acknowledges that the State, and its employees and consultants, are subject to the provisions of the Fair Political Practices law of California (Government Code Section 81000, et seq., and all regulations adopted thereunder, including, but not limited to, Title 2, California Code of Regulations Section 18700) and the Contractor shall comply promptly with any requirement thereunder. The Contractor shall require any of its personnel to whom the legal requirements apply to file Statements of Economic Interests in compliance with the State's Conflict of

Interest Code (Title 2, California Code of Regulations, Section 54400

2. The Contractor affirms that the Contractor shall not use any information resulting from this Agreement to advantage the Contractor's other business operations.

B. Publicity

No publicity release or announcement concerning this Agreement or the transactions contemplated herein shall be issued by the Contractor without advance written approval by the State.

C. Services or Procurement Resulting from Agreement

Neither the Contractor, nor any of its subsidiaries, officers or directors, may submit a bid or be awarded a contract for the provision of services, procurement of goods or supplies, or any other related action which is required, suggested, or otherwise deemed to be an outgrowth of the advice or recommendations that the Contractor provides under this Agreement.

IV. REPRESENTATIONS AND WARRANTIES

A. Power and Authority

1. The Contractor represents and warrants that it has the power and authority to enter into this Agreement and to carry out its obligations hereunder. The execution of this Agreement has been duly authorized by the Contractor and no other proceeding on the part of the Contractor is necessary to authorize this Agreement. The Contractor has completed, obtained and performed all registrations, filings, approvals, authorizations, consents or examination required by any government or governmental authority for its acts contemplated by this Agreement.

2. The Contractor's participating providers are duly licensed or certified, as required by the laws of this state. The Contractor routinely monitors its participating providers' licenses to ensure that they are current. The Contractor's participating providers have no Department of Health Services or Medical Board of California licensing restrictions.

B. Legal Proceedings

Except as specifically disclosed in writing to the Program by the Contractor prior to the date hereof, and approved by the State in writing, the Contractor certifies that there are no suits, investigations, or other proceedings pending or threatened against the Contractor which would have an effect on the Contractor's ability to perform under this Agreement.

C. Financial Information

The Contractor certifies that all financial information delivered to the State, including, without limit, audited financial statements and related financial periodic information relating to the Contractor, its parent corporation, its affiliates and subsidiaries, its partners or joint ventures, or any Guarantor, fairly and accurately represents such financial condition and has been prepared in accordance with Generally Accepted Accounting Principles unless otherwise noted in such information. Unless the Contractor so informs the State, the Contractor certifies that no material adverse change in such financial condition has occurred.

D. Reporting Accuracy

The Contractor certifies that all reports, documents, instruments, papers, data, information and forms of evidence delivered to the State with respect to this Agreement are accurate and correct, and complete insofar as completeness may be necessary to give the State true and accurate knowledge of the subject matter thereof, and do not contain any material misrepresentations or omissions.

E. Agreement Does Not Violate Law

Neither the execution of this Agreement nor the acts contemplated hereby nor compliance by the Contractor with any provisions hereof shall:

1. Violate any provision of the charter documents of the Contractor;

2. Violate any statute or law or ordinance or any judgment, decree, order, regulation or rule of any court or governmental authority applicable to the Contractor; or

3. Violate, or be in conflict with, or constitute a default under, or permit the termination of, or require the consent of any person under, any agreement to which the Contractor may be bound, the violation of which in the aggregate would have a material adverse effect on the properties, business, prospects, earnings, assets, liabilities or condition (financial or otherwise) of the Contractor.

F. Due Organization

The Contractor is duly organized, validly existing and in good standing under the laws of the State of its incorporation or organization.

G. Signature Authorization

The person signing this Agreement warrants that he/she is an agent of the Contractor and is duly authorized to enter into this Agreement on behalf of the Contractor.

V. GENERAL PROVISIONS

A. Binding Effect

This Agreement, any instrument or agreement executed pursuant to this Agreement, and the rights, covenants, conditions and obligations of the Contractor and the State contained therein, shall be binding upon the parties and their successors, assignees and legal representatives.

B. Public Assistance Hiring Preference

As the maximum amount of this Agreement exceeds $200,000 the Contractor shall give priority consideration in filling vacancies for positions funded by this contract to recipients of California public assistance Programs, in accordance with the criteria and exemption set forth in Section 10353 of the Public Contract Code, and Section 11349 of the Welfare and Institutions Code. This requirement shall not interfere with or require a violation of a collective bargaining agreement, a federal affirmative action obligation for hiring disabled veterans of the Vietnam era, or nondiscrimination compliance laws of California and does not require the employment of unqualified recipients of aid.

C. Contractor Federal Employer/Contractor ID Number

The Contractor is hereby notified of its responsibility to use the assigned Contractor Federal Identification Number contained on the front page of the Agreement on each subsequent contract entered into with the State of California

D. Taxes

The State is exempt from federal excise taxes and shall not make any payment for any personal property taxes levied on the Contractor or any taxes levied on employee wages. The only taxes the State shall pay on

the services rendered pursuant to this Agreement are state and local sales or use taxes.

E. Incorporation of Amendments to Applicable Laws

Any references to sections of federal or state statutes or regulations shall be deemed to include a reference to any amendments thereof and any successor provisions thereto.

F. Ambiguities Not Held Against Drafter

This contract having been freely and voluntarily negotiated by all parties, the rule that ambiguous contractual provisions are construed against the drafter of the provision shall be inapplicable to this contract.

G. Force Majeure

Neither party to this Agreement shall be liable for damages resulting from delayed or defective performance when such delays arise out of causes beyond the control and without the fault or negligence of the offending party. Such causes may include, but are not restricted to, Acts of God or of the public enemy, acts of the State in its sovereign capacity, fires, floods, power failure, disabling strikes, epidemics, quarantine restrictions, and freight embargoes.

H. Waivers

No delay on the part of any party in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall any waiver on the part of any party of any right, power or privilege hereunder, nor any single or partial exercise of any right, power or privilege hereunder, preclude any other or further exercise thereof or the exercise of any other right, power or privilege hereunder.

I. Titles/Section Headings

Titles or headings are not part of this Agreement, are for convenience of reference only, and shall have no effect on the construction or legal effect of this Agreement.

J. Counterparts

This Agreement may be executed in one or more counterparts, each of, which shall be deemed an original, but all of which together shall constitute one and the same instrument.

K. Cumulative Remedies

The rights and remedies provided herein are cumulative and are not exclusive of any rights or remedies, which any party may otherwise have at law or in equity.

L. Entire Agreement/Incorporated Documents/Order of Precedence

1. This Agreement contains all representations and the entire understanding between the parties hereto with respect to the subject matter hereof. Any prior correspondence, memoranda, or agreements are replaced in total by this Agreement.

2. This Agreement shall consist of the terms of this Agreement, and all attached documents which are expressly incorporated herein. In addition to those documents, which are incorporated elsewhere in this Agreement, the following documents are, by this reference, also incorporated herein:

   _____
   _____
   _____

3. In the event there are any inconsistencies or ambiguities among the terms of this Agreement and incorporated documents, the following order of precedence shall be used: (i) applicable laws; (ii) the terms and conditions of this Agreement, including attachments; and (iii) any other provisions, terms, or materials incorporated herein.

M. Dispute Resolution

Any dispute concerning a question of fact arising under the terms of this Agreement which is not disposed of within a reasonable period of time by Contractor and State employees normally responsible for the administration of this Agreement shall be brought to the attention of the Executive Officer (or designated representative) of each organization for joint resolution. At the request of either party, the State shall provide a forum for the discussion of the disputed item(s). If agreement cannot be reached through the application of high level management attention, either party may assert its other rights and remedies within this Agreement or within a court of competent jurisdiction.

The State and Contractor agree that, the existence of a dispute notwithstanding, they shall continue without delay to carry out all their responsibilities under this Agreement which are not affected by this dispute.

EXHIBIT E

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EXHIBIT E
FEDERAL TERMS AND CONDITIONS

I. Clean Air and Water

A. The Contractor agrees under penalty of perjury it is not in violation of any order or resolution which is not subject to review promulgated by the State Air Resources Board or any air pollution district.

B. The Contractor agrees under penalty or perjury it is not subject to any cease and desist order which is not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions, or is not finally determined to be in violation of provisions of federal law relating to air or water pollution.

C The Contractor agrees to comply with all the requirements of Section 114 of the Clean Air Act as amended (42 U.S.C. 7401 et seq., as amended by Public Law 95-95), and Section 308 of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq., as amended by Public Law 92500), respectively, relating to inspection, monitoring, entry, reports, and information, as well as all other requirements specified in Section 114 and Section 308 of the Air Act and the Water Act, respectively, and all regulations and guidelines issued to implement those Acts before the award of this contract.

II. Small, Minority and Women Owned Business Subcontracting

It is federal policy that the Contractor award a fair share of any subcontracts awarded under this contract to small, minority and women owned business firms. The Contractor agrees to comply with this policy.

III. Inventory of Equipment

The State does not anticipate that the Contractor will purchase any equipment for use in administering this Agreement. The State reserves title to all equipment of any kind purchased from, advanced, or reimbursed by, funds from the State, and not fully consumed in the performance of this Agreement. Inventory and disposition of such equipment is subject to the provisions of this paragraph, as well as paragraphs 1, 2, and 3 below:

A. The Contractor shall, at the request of the State, submit an inventory of equipment purchased under this Agreement.

B. At the termination of this Agreement, the Contractor shall provide a final inventory to the State and shall, at that time, query the State as to the State's requirements for returning said equipment. Final disposition of

such equipment shall be at State expense and in accordance with State instructions issued immediately after the receipt of the final inventory.

C. Before equipment purchases made by the Contractor are reimbursed by the State, the Contractor must submit copies of paid vendor receipts, identifying the purchase price, a description of the item, the serial number, model number and location of the equipment during the contract term. These receipts shall be attached to the Contractor's invoice for the month in which the equipment was purchased.

IV. Environmental Tobacco Smoke Certification

By signing this Agreement, the Contractor certifies that it will comply with the requirements of Public Law 103-227, also known as the U.S. Pro-Children Act of 1994 (20 USC 6081 et seq.) and will therefore not allow smoking within any portion of any indoor facility used for the provision of health services for children. The Contractor further agrees that it will insert this certification into any subcontracts which provide children's health services. The Contractor understands that failure to comply with the provisions of this law may result in the imposition of an administrative compliance order on the responsible entity.

V. Federal Lobbying Certification

A. The Contractor shall comply with Section 1352 of Title 31, United States Code regarding prohibitions against using federal funds for lobbying.

B. By signing this Contract, the signer certifies, on behalf of the Contractor, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of an agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this funded contract, Federal grant, or cooperative agreement, and the extension, continuations, renewal, amendment, or modification of this Federal contract, grant or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the Contractor shall complete and submit Standard Form LLL,

"Disclosure of Lobbying Activities" in accordance with its instructions.

3. The Contractor shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontractors, sub-grants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

VI. Federal Payment Restrictions for Various Services

A. The Contractor shall exclude all payments for any item or service, with the exception of an emergency service or item provided in an emergency room of a hospital, to any individual or entity which is under exclusion by the U.S. Department of Health and Human Services from participation under Titles V, XVIII, XIX, XX, or XXI of the Social Security Act, or any item or service made under the medical direction or on the prescription of a physician who is under such exclusion. (42 U.S.C. 1396b (i) Sec. 1903 (2))

B. The Contractor shall make determinations of individuals and entities that are so excluded as part of their initial and ongoing credentialing process of providers and facilities who are participating in the Program.

VII. Federal Ownership Disclosure Requirements

A. The Contractor shall provide to the State, on a yearly basis, an ownership disclosure statement, on a format to be provided by the State. The statement shall disclose the name of any individual or entity that has a five percent or more ownership or control interest as defined under 42 U.S.C. Section 1320 a-3 (3).

B. In addition, the Contractor shall require and collect ownership disclosure statements from the subcontracted providers of services to the Program (including hospitals, rural primary care hospitals, skilled nursing services, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, independent clinical laboratories, renal disease facilities, and other entities listed in 42 U.S.C. 1320 a.-3, but not individual

practitioners or groups of practitioners). The ownership disclosure statements shall be on a format to be provided by the State, shall be maintained by the Contractor for certification purposes, and shall be provided to the State upon request. The Contractor shall require the statements to be filed upon a provider's entry into the Contractor's health plan and at least yearly thereafter.

VIII. Convicted Offenses Disclosure

The Contractor shall require hospitals, nursing facilities, and other subcontracting provider entities participating in the Program to make the disclosures required by 42 U.S.C. Section 1320 a-5 et seq., regarding certain convicted offenses or exclusions from state or federal health programs of the provider's owners, officers, directors, agents or managing employees. These disclosures shall be made to the Contractor on behalf of the State. The Contractor will immediately notify the State of any such disclosing entities, so that the State may notify the Inspector General of the U.S. Department of Health and Human Services. The Contractor is not required in this Item VIII to require disclosures from individual practitioners or groups of practitioners.

IX. Debarment Certification

The Contractor shall comply with all requirements, terms and conditions set forth in Attachment V, Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions, and its instructions which was submitted as part of the Contractor's proposal.

X. Equal Employment Opportunity

The Contractor shall comply with all requirements of federal Executive Order 11246, entitled "Equal Employment Opportunity", as amended by Executive Order 11375, entitled "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by federal regulations (41CFR Part 60, entitled "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor").

GEOGRAPHIC AREA GRID INSTRUCTIONS

FOR PLANS CURRENTLY PARTICIPATING IN HFP

There are two versions of Attachment I (Geographic Area Grid):

- One is the Geographic Area Grid from your plan's current Healthy Families Program contract for the period July 1, 2004 through June 30, 2005. MRMIB will send your plan's current grid showing service areas for 2004-05.

- The other is a blank Proposed Geographic Area Grid to indicate proposed changes in your plan's service area(s) for July 1, 2005 through June 30, 2006.

1. If your plan has no changes from the current Attachment I, then write **NO CHANGES** on the Current Geographic Area Grid document.

2. **The Proposed Geographic Area Grid should only be filled out if your plan will be expanding, deleting or otherwise changing its service area during the upcoming contract year. The grid should be filled out in its entirety as follows:**

    a. Place an **X** in the grid where the plan has full county coverage.
    b. Place an **X*** in the grid where the plan has coverage for all of Los Angeles County other than Catalina Island.
    c. Place a **P** in the grid where the plan covers only part of a county.

3. Allowable reasons for changes in service areas include:

    a. Service area changes that have been approved by the California Department of Managed Health Care (DMHC) or the Department of Insurance (DOI) for either the addition of a new service area or the removal of an existing service area.
    b. A change in zip code coverage approved by DMHC or DOI which would either cause coverage in a county to move from a partial area of coverage or to a full area of coverage.
    c. A service area with a DMHC license for which the plan did not serve HFP subscribers in the current year but would like to add for the upcoming year.

    Note on proposed service area expansions: You may list an area for which your plan does not now have a current license **if you have already submitted a request for approval to DMHC or DOI, and you expect to receive approval prior to April 1, 2005**. However, in the submission due to MRMIB on December 10, 2004, you must list these zip codes and/or counties on the **"Proposed Zip Codes"** sheet in the Zip Code Workbook and include a copy of the request submitted to your regulator (DMHC or

DOI). **By April 1, 2005, MRMIB must receive a copy of the notification from DMHC or DOI approving the service area changes, in order for the new service areas to be available as a choice to HFP subscribers in those areas during open enrollment for the 2005-06 benefit year.** (Open enrollment will take place April 15 through May 31, 2005.) Any service areas approved by DMHC or DOI after April 1, 2005, may or may not be approved by MRMIB, at its discretion, for HFP services.

4. For all counties in which you placed a "P" in the Geographic Area Grid, as well as all service areas for which DMHC or DOI approval is pending, complete the Zip Code Workbook. Instructions for completion are contained in the first tab of the workbook.

5. A responsible plan official must sign and date that he/she has reviewed the submission of either the Current Geographic Area Grid or the Proposed Geographic Area Grid for correctness and accuracy.

6. The signed Attachment I, the completed Zip Code Workbook, and documentation of any pending requests to DMHC or DOI for service area changes must be received by MRMIB **no later than 3 p.m. December 10, 2004**. Send to:

   Sarah Soto-Taylor
   Managed Risk Medical Insurance Board
   1000 G Street , Suite 450
   Sacramento, CA 95814

   Please send an electronic copy as well to wsanchez@mrmib.ca.gov

7. By **April 1, 2005**, submit the required documentation of DMHC or DOI approval of service area changes to Sarah Soto-Taylor at the above address. If approval has not been received by April 1st, please notify her immediately at ssoto@mrmib.ca.gov on the status of your pending request.

FOR PLANS NOT CURRENTLY PARTICIPATING IN HFP

1. Complete the Proposed Geographic Area Grid to show the HFP service areas your plan proposes to serve for the period July 1, 2005 through June 30, 2006. The grid should be filled out in its entirety as follows:

   a. Place an **X** in the grid where the plan will provide full county coverage.
   b. Place an **X*** in the grid where the plan will provide coverage for all of Los Angeles County other than Catalina Island.
   c. Place a **P** in the grid where the plan will cover only part of a county.

Note to new plans: You may list an area for which your plan does not now have a current license **if you have already submitted a request for approval to DMHC or DOI, and you expect to receive approval prior to April 1, 2005**. However, in the submission due to MRMIB on December 10, 2004, you must list these zip codes and/or counties on the **"Proposed Zip Codes"** sheet in the Zip Code Workbook and include a copy of the request submitted to your regulator (DMHC or DOI). **By April 1, 2005, MRMIB must receive a copy of the notification from DMHC or DOI approving the service areas, in order for your plan to be available as a choice to HFP subscribers in those areas during open enrollment for the 2005-06 benefit year.** (Open enrollment will take place April 15 through May 31, 2005.) Any service areas approved by DMHC or DOI after April 1, 2005, may or may not be approved by MRMIB, at its discretion, for HFP services.

2. For all counties in which you placed a "P" in the Geographic Area Grid, as well as all counties and/or zip codes for which DMHC or DOI approval is pending, complete the Zip Code Workbook. Instructions for completion are contained in the first tab of the workbook. In the "New Zip Codes" tab, list all counties and/or zip codes in the counties with partial coverage for which your plan is already approved by DMHC or DOI. In the "Proposed Zip Codes" tab, list all pending counties and/or zip codes for which DMHC or DOI approval has not been received.

3. A responsible plan official must sign and date that he/she has reviewed the submission of the Proposed Geographic Area Grid for correctness and accuracy.

4. The signed Attachment I, the Zip Code Workbook, and documentation of pending requests to DMHC or DOI for licensure and/or service area changes must be received by MRMIB **no later than 3 p.m. December 10, 2004.** Send to:

   Sarah Soto-Taylor
   Managed Risk Medical Insurance Board
   1000 G Street , Suite 450
   Sacramento, CA 95814

   Please send an electronic copy as well to wsanchez@mrmib.ca.gov.

5. By **April 1, 2005**, submit the required documentation of DMHC or DOI approval of licensure and/or service area changes to Sarah Soto-Taylor at the above address. If approval has not been received by April 1st, please notify her immediately at ssoto@mrmib.ca.gov on the status of your pending request.

CURRENT GEOGRAPHIC AREA GRID

SAMPLE
Current Grid
(Plan specific grid will be sent to currently participating plans)

Region	COUNTIES	Licensed Service Area
3	Alameda	
1	Alpine	
1	Amador	
1	Butte	
1	Calaveras	
1	Colusa	
3	Contra Costa	
1	Del Norte	
1	El Dorado	
2	Fresno	
1	Glenn	
1	Humboldt	
2	Imperial	
1	Inyo	
2	Kern	
1	Kings	
1	Lake	
1	Lassen	
5	Los Angeles	X*
2	Madera	
3	Marin	
2	Mariposa	
1	Mendocino	
2	Merced	
1	Modoc	
1	Mono	
1	Monterey	
2	Napa	
1	Nevada	
4	Orange	
1	Placer	
1	Plumas	
6	Riverside	P
2	Sacramento	X
1	San Benito	
6	San Bernardino	P
6	San Diego	
3	San Francisco	

CODE

X = Full county coverage
(Licensed area covers all zip codes)

X* = Full county coverage
in Los Angeles except Catalina Island

P = Partial county coverage
(License area covers some zip codes)
If a plan has partial coverage, list those zip codes covered on the diskette provided.

Leave box blank if no county coverage

Region	COUNTIES	Licensed Service Area
2	San Joaquin	
2	San Luis Obispo	
3	San Mateo	
4	Santa Barbara	
3	Santa Clara	
2	Santa Cruz	
1	Shasta	
1	Sierra	
1	Siskiyou	
2	Solano	
2	Sonoma	
2	Stanislaus	
1	Sutter	
1	Tehama	
1	Trinity	
1	Tulare	
1	Tuolumne	
4	Ventura	
1	Yolo	
1	Yuba	

CODE

X = Full county coverage
(Licensed area covers all zip codes)

P = Partial county coverage
(License area covers some zip codes)
If a plan has partial coverage,
list those zip codes covered on the
diskette provided.

Leave box blank
if no county coverage

Projected Geographic Areas of Service for July 1, 2005 - June 30, 2006 Certification

Plan Name _____

I certify that the Geographic Area Grid for the period presented is accurate and appropriate for the California Healthy Families Program.

By: _____ _____
Print name Date

PROPOSED GEOGRAPHIC AREA GRID
July 1, 2005 - June 30, 2006

Region	COUNTIES	Licensed Service Area
3	Alameda	
1	Alpine	
1	Amador	
1	Butte	
1	Calaveras	
1	Colusa	
3	Contra Costa	
1	Del Norte	
1	El Dorado	
2	Fresno	
1	Glenn	
1	Humboldt	
2	Imperial	
1	Inyo	
2	Kern	
1	Kings	
1	Lake	
1	Lassen	
5	Los Angeles	
2	Madera	
3	Marin	
2	Mariposa	
1	Mendocino	
2	Merced	
1	Modoc	
1	Mono	
1	Monterey	
2	Napa	
1	Nevada	
4	Orange	
1	Placer	
1	Plumas	
6	Riverside	
2	Sacramento	
1	San Benito	
6	San Bernardino	
6	San Diego	
3	San Francisco	

CODE

X = Full county coverage
(Licensed area covers all zip codes)

X* = Full county coverage
in Los Angeles except Catalina Island

P = Partial county coverage
(License area covers some zip codes)
If a plan has partial coverage,
list those zip codes covered on the
diskette provided.

Leave box blank
if no county coverage

Region	COUNTIES	Licensed Service Area
2	San Joaquin	
2	San Luis Obispo	
3	San Mateo	
4	Santa Barbara	
3	Santa Clara	
2	Santa Cruz	
1	Shasta	
1	Sierra	
1	Siskiyou	
2	Solano	
2	Sonoma	
2	Stanislaus	
1	Sutter	
1	Tehama	
1	Trinity	
1	Tulare	
1	Tuolumne	
4	Ventura	
1	Yolo	
1	Yuba	

CODE

X = Full county coverage
(Licensed area covers all zip codes)

P = Partial county coverage
(License area covers some zip codes)
If a plan has partial coverage,
list those zip codes covered on the
diskette provided.

Leave box blank
if no county coverage

Proposed Geographic Service Areas for July 1, 2005 - June 30, 2006 Certification

Plan Name _____

I certify that the Geographic Area Grid for the period presented is accurate and appropriate for the California Healthy Families Program.

By: _____ _____
Print name Date

_____ _____
Signature Phone number

_____
Title

Instructions

Currently Participating Plans Only:
There are two versions of Attachment I. One is the grid from your plan's current Healthy Families Program contract. Please review this document for accuracy. If counties of coverage have changed, fill out the Proposed Geographic Area Grid with the correct Xs and Ps. This workbook is for those counties in which your plan does not provide complete coverage for all zip codes. In any county where you have inserted "P" on the grid, please review the enclosed listing and make the changes on the tabs as indicated.

New Plans Only:
Complete the Proposed Geographic Area Grid in Attachment I to show the HFP service areas your plan proposes to serve for the 2005-06 contract year. Refer to the Attachment I instructions for more details. To complete the Workbook, start with Step Three below.

Step One (for currently participating plans only)
Review the list provided on tab "Current Zip Codes." This tab is locked and no changes can be made to the worksheet. If the worksheet is correct as provided, write "No Changes" on the worksheet. Complete the signature section.

Step Two (for currently participating plans only)
If the Current Zip Codes listing shows a zip code that you do not cover, enter that information on the tab "Deleted Zip Codes." Proceed through the listing and enter all zip codes that you do not provide coverage for.

Step Three
Current Plans Only: If there are any zip codes you cover that are not listed in the Current Zip Codes listing, enter those zip codes on the tab "New Zip Codes." Proceed through the listing and enter all zip codes that need to be added to your coverage area. Do not list any zip code or county for which DMHC or DOI approval is pending.
New Plans Only: If you already have DMHC or DOI approval for particular zip codes and/or counties, list them on the tab "New Zip Codes."

Step Four (current and new plans)
If you have proposed new coverage areas to DMHC or DOI and approval is pending, enter those zip codes and/or counties on the tab "Proposed Zip Codes."

Current zip codes included in plan's partial service areas

Co	Zip Code	County

If entire county is covered, please disregard this worksheet

[MRMIB WILL SEND EACH CURRENTLY PARTICIPATING PLAN ITS CURRENT SERVICE AREAS]

Deleted zip codes no longer Included in plan's partial service areas

Please list the zip codes to delete from the current coverage area

Co	Zip Code	County

New zip codes included in plan's partial service areas

Please list the zip codes to add to the current coverage area

Co	Zip Code	County

Proposed zip codes and/or counties pending regulatory approval.

Co	Zip Code	County

ATTACHMENT II
PROVIDER DATA FILE REQUIREMENTS

Provider Data File Requirements

Data Elements

The provider data file should contain one record for each unique provider location. In other words, a provider that practices in three different offices should be listed three times. Individual and facility records should be contained in separate files. If codes are used for any fields (e.g., specialties, hospital affiliations, etc.), an appropriate decode table should be included. The following items should be included, with one field per item:

For Both Individual Providers and Facilities

1. Address
2. Suite
3. City
4. State
5. ZIP
6. County
7. Phone number (with area code)
8. Plan Identifier
9. Tax ID
10. PCP / Clinic ID

For Facility Providers

1. Name
2. Facility Type (Hospital)

For Individual Providers

1. Social Security Number
2. DEA Number
3. Last Name
4. First Name
5. Middle Name or Initial
6. Suffix
7. Degree
8. Gender
9. Role (PCP, Referral, Self-Referral)
10. Specialty(ies)
11. State License Number
12. Date of Birth
13. Board Status
14. Open/Closed Practice Indicator
15. Languages Spoken
16. Hospital Affiliation(s)
17. Clinic/Group/IPA Affiliation(s)

Acceptable File Format

Delimited ASCII file with a field description is the only acceptable file format.

Acceptable Media Format

Internet transfer is the only acceptable media format. Feel free to use some form of common data compression (such as PKZIP). If data compression is used, please note the method of compression.

Sample File Format

The file structures shown below represents a recommended file format for submitting physician (and other healthcare provider) data, and facility data. **Note that the file format must comply with the requirements listed on page 1.**

Provider File

Field Name	Width	Occurrences	Description / Definition
Plan Identifier	15	1	Name of the plan or panel
First	25	1	First name field
Middle	25	1	Middle name/initial field
Last	70	1	Last name field
Suffix	25	1	Jr, Sr, III, IV, etc.
Gender	1	1	Male, Female, or Unknown
Degree	25	1	MD, DO, etc.
Address	60	1	Street address or physician office location
Suite	30	1	Secondary address
City	45	1	
State	2	1	
Zip	5	1	
County	45	1	
Phone	10	1	Area code and number without dashes or spaces
Open Practice	1	1	Accepting patients, closed, unknown
PCP/Clinic ID	15	1	This is an identifier meaningful to the health plan to be used for enrollment purposes.
DEA Number	15	1	Drug enforcement agency number
License number	9	1	
DOB	8	1	Physician's Date of Birth (MMDDYYYY)
SSN	9	1	Physician's Social Security Number
Tax ID	9	1	Federal Tax ID
Role	1	1	Role within the plan or panel; Primary care, Referral, or Self-referral
Specialty	60	8	Field indicating practice specialty; if a code is used, a translation table must be included
Spoken Languages Language Location/Provider	 60 1	8	Field indicating language spoken at the provider's location or by provider; if a code is used, a translation table must be included. Language Language spoken at location (L), by Provider (P), or both (B)
Board Status	1	8	Certified, Eligible, Not Certified, or Unknown
Hospital	60	16	Field indicating Physician's hospital affiliation
Clinic Group	50	8	Name of medical group, IPA or clinic

Facility File

Field Name	Width	Occurrences	Description / Definition
Plan Identifier	15	1	Name of the plan or panel
Hospital Name	70	1	Name of facility
Address	60	1	Address of facility
Suite	30	1	Secondary address
City	45	1	
State	2	1	
Zip	5	1	
County	45	1	
Phone	10	1	Area code and number without dashes or spaces
Tax ID	9	1	Federal Tax ID
Facility Type	8	1	Hospital, Clinics, SNF etc.

ATTACHMENT III
SCHEDULE OF PERFORMANCE MEASURES
Childhood Indicators - Ages 12 Months Through 18 Years

Note This schedule outlines the performance measures to be reported by health plans during the term of this contract. The description of HEDIS® measures contained in this schedule of performance measures is not meant to be a comprehensive description of required HEDIS® measures. Plans are expected to have the most current HEDIS® information and to follow the specifications for the following measures in that document. MRMIB will provide specifications for the 120-day Initial Health Assessment along with the format that plans are to use to submit their performance reports.

FOR THE 2005-06 CONTRACT PERIOD

1) CHILDHOOD IMMUNIZATION STATUS (HEDIS® Measure)

The percentage of HFP enrolled children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had not more than one break in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the following immunizations:

- Four DTP or DTaP vaccinations by the second birthday with at least one diphtheria and one tetanus falling on or between the child's first and second birthdays.
- Three polio (IPV or OPV) vaccinations by the second birthday
- One MMR between the first and second birthdays
- Three H influenza type B vaccinations with different dates of service by the child's second birthday and with at least one of them falling on or between the first and second birthdays
- Three hepatitis B vaccinations by the second birthday (with one of them falling between the six month and the second birthday)
- At least one chicken pox vaccination (VZV), with a date of service falling on or between the child's first and second birthdays
- A combined rate including children who have received all of the immunizations above.

2) CHILDREN'S ACCESS TO PRIMARY CARE PROVIDERS (HEDIS® Measure)

The percentage of children who have had at least one visit to a pediatrician, family physician, and other health care provider during the reporting year. Four separate cohorts are reported:

- Percentage of children age 12 through 24 months who were continuously enrolled during the reporting year who have had one (or more) visits with a health plan primary care provider during the reported year.
- Percentage of children age 25 months through 6 years who were continuously enrolled during the reporting year who have had one (or more) visits with a health plan primary care provider during the reported year.
- Percentage of children age 7 through 11 years who were continuously enrolled during the reporting year and the year prior who have had one (or more) visits with a health plan primary care provider during the reporting year or the year preceding the reporting year.
- Percentage of adolescents 12-18 years of age who were continuously enrolled during the reporting year and the year prior who have had one (or more) visits with a health plan primary care provider during the reporting year or the year preceding the reporting year.

3) *WELL CHILD VISIT IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS* (HEDIS® Measure)

The percentage of HFP enrolled members who were age 3 through 6 years during the reporting year who were continuously enrolled during the reporting year and who received one or more well-child visit(s) with a primary care provider during the reporting year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure.

4) *ADOLESCENT WELL-CARE VISITS* (HEDIS® Measure)

The percentage of HFP enrolled members who were 12 through 18 years during the reporting year who were continuously enrolled during the reporting year and who had at least one comprehensive well-care visit with a primary care provider during the reporting year. Members who have had not more than one break in enrollment of up to 45 days per year should be included in this measure.

5) *ALCOHOL AND OTHER DRUG SERVICES UTILIZATION* (HEDIS® Measure)

Percentage of Members Receiving Inpatient, Intermediate, and Ambulatory Services.

The number and percentage of HFP members receiving alcohol and other drug services during the reporting year in the following categories: any alcohol and other drug services; inpatient alcohol and other drug services; intermediate alcohol and other drug services; and ambulatory alcohol and other drug services.

6) *FOLLOW-UP AFTER HOSPITALIZATION FOR SELECTED MENTAL ILLNESS* (HEDIS® Measure)

The percentage of plan members age 6 and over who were hospitalized for selected mental disorders and who were seen on an outpatient basis by a mental health provider within 7 and 30 days after discharge:

- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to 30 days after hospital discharge, ***and***
- The percentage of discharges for members who had an ambulatory or day/night mental health visit on the date of discharge, up to 7 days after hospital discharge.

7) *USE OF APPROPRIATE MEDICATIONS FOR ASTHMA* (HEDIS® Measure)

The percentage of enrolled members 5 through 18 years of age during the measurement year, who were identified as having persistent asthma during the year prior to the measurement year and who were appropriately prescribed medication during the measurement year.

8) *INITIAL HEALTH ASSESSMENT (Non-HEDIS® Measure)*

The percentage of newly enrolled HFP subscribers who received a health assessment within the first 120 days of the subscribers' enrollment in the plan or an assessment in the 12 months immediately preceding enrollment in the plan.

FOR THE 2006-07 CONTRACT PERIOD

All measures listed above for 2005-06 and:

MENTAL HEALTH UTILIZATION (HEDIS® Measure)

The number and percentage of members, by age and sex, receiving mental health services during the measurement year in four categories of service:

- any mental health services (inpatient, day/night, ambulatory)
- inpatient mental health services
- day/night mental health services
- ambulatory mental health services

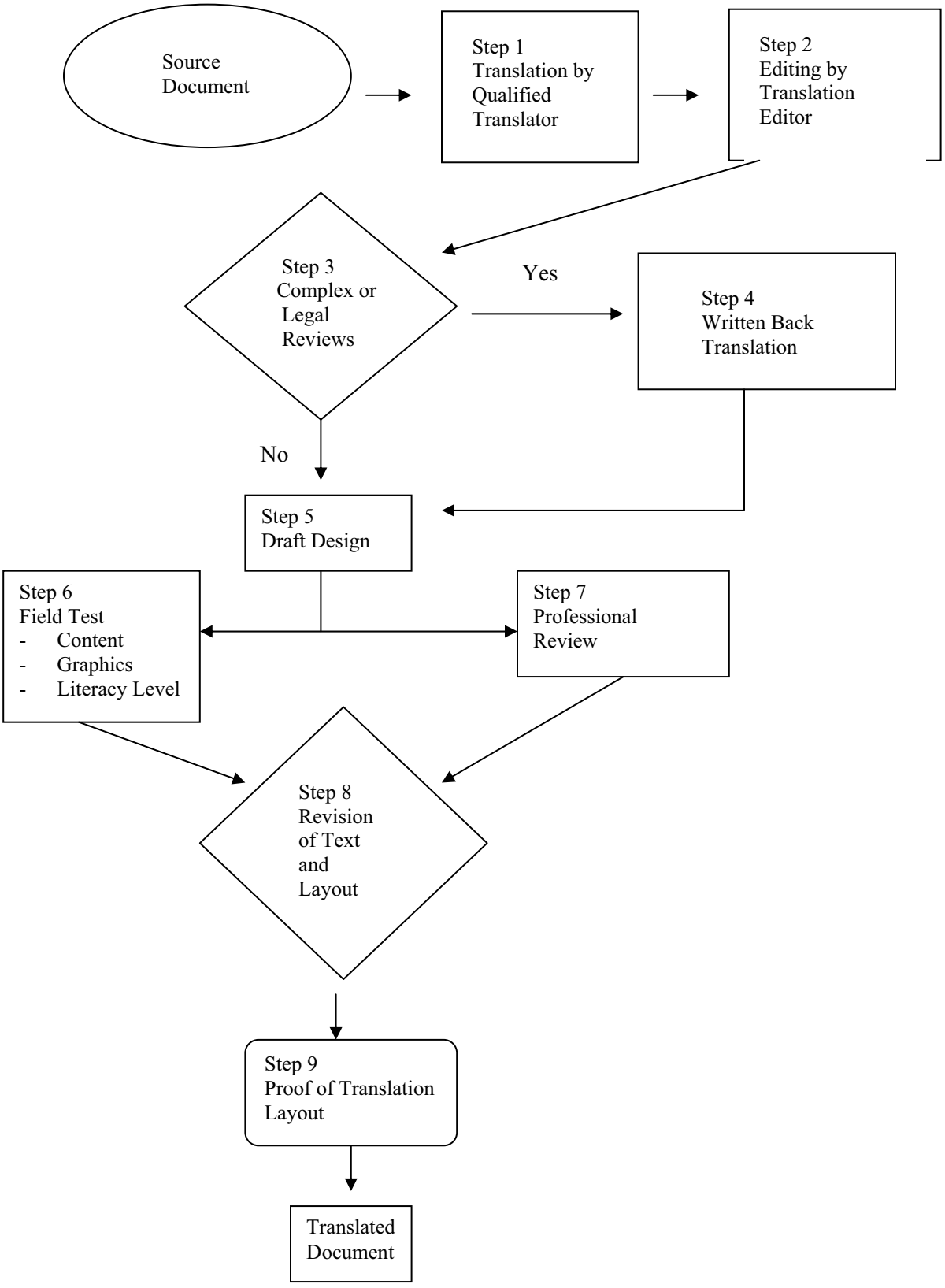
FOR THE 2007-08 CONTRACT PERIOD

All measures listed above for 2006-07 and:

CHLAMYDIA SCREENING IN WOMEN (HEDIS® Measure)

The percentage of women 16-18 years of age who were identified as sexually active, who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during that time and who had at least one test for Chlamydia during the measurement year.

Translated Process Flowchart



Translation Process Flowchart Instructions

Using the Translation Process Flowchart

Choosing the correct steps depends on the document to be translated.

Steps 1 & 2: By using two different qualified translators (one to translate and the other to edit), the quality of the translation will be enhanced, the risk of error will be reduced, and the diversity within a culture will be considered. It is recommended that familiarity with the regional language variations and cultural diversity of the intended audience be considered in the selection of the translation team. Word processing may be done by the Qualified Translator, Translation editor, or a word processor. Depending upon the target language and the number of translation process steps that are needed and used, word processing may take place at any point along the process.

Step 3: Complex and legal documents require a more intensive review.

Step 4: If it has been determined in Step 3 that the document is a complex or legal document, then a back translation is encouraged.

Step 5: A pre-field test version of the document is rendered and proofed, including layout and graphics.

Step 6: During field testing, the document is tested with members of the intended audience. It serves a four-fold purpose:

1. To ensure that the document conveys the desired message to the intended audience;
2. To ensure that the literacy level is appropriate for the intended audience;
3. To allow correction of inaccuracies and misconceptions; and
4. Identify and correct geographical or regional differences in language.

Step 7: During professional review the document is sent to health professionals and experts who are literate in both English and the target language, familiar with the content areas, and with the intended audience.

Step 8: The results of steps 7 and 8 are incorporated into the document. Revisions to the source document may be made to address problematic issues uncovered during the field test and professional review.

Step 9: The combined layout and revised text are proofread.

DEFINITIONS OF TERMS IN THE TRANSLATION PROCESS

QUALIFIED TRANSLATOR

- Formal education in the target language. Ability to read, write and understand the target language.
- Ability to read and understand the source language.
- Knowledge and experience with culture(s) of the intended audience.
- Health and managed care background is recommended.

TRANSLATION EDITOR

- A translator other than the original "Qualified Translator."
- Formal education in the target language. Ability to read, write and understand the target language.
- Knowledge and experience with culture(s) of the intended audience.
- Ensures the translation conveys all source document information (grammar, flow, completeness, accuracy, punctuation, spelling, accents/diacritical marks, etc.)
- Health and managed care background is recommended.

PROOFREADER

- A Qualified Translator other than the translator who did the word-processing, desktop publishing, or typesetting. May be performed by the Qualified Translator or Translation Editor as long as this individual did not perform the word processing, desktop publishing or typesetting.
- Formal education in the target language. Ability to read, write, and understand the target language.
- Responsible for punctuation, spelling, accents/diacritical marks, and typographical errors.

PROFESSIONAL REVIEWER

- Experience with health care and topic of the document.
- Knowledge and experience with culture(s) of the intended audience.
- Ability to read and understand the target language.
- Direct experience working with intended audience.
- Knowledge of managed care preferred.

FIELD TESTING

- Conducted with a minimum of seven end-users per language.
- Field test coordinator-experience with health education materials development.
- Must keep documentation of process, data, and results of each field test on file.
- Process may include individual interviews, surveys, and focus groups.
- Field test should examine word choices, clarity of concept conveyed, cultural appropriateness, acceptability, appeal, literacy, graphic appeal, and appropriateness.

BACK TRANSLATION

- Conducted by a Qualified Translator other than the original translator, editor, and proofreader.
- Written translations from target language to source language.
- For legal documents to ensure accuracy and completeness.

ATTACHMENT V
CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS

OVERVIEW

In accordance with 45CFR Part 76, State contractors who receive federal funds through the Title XXI State Children's Health Insurance Program (In California, the Healthy Families Program and Access for Infants and Mothers Program) must certify at the time of submitting a model contract proposal, that they are not debarred or otherwise excluded by the Federal government from receiving federal funding. Under this federal rule, entities who contract with the State and who are being considered for federal funding are considered to be "lower tier participants" by the federal government. Subcontractors who will receive federal funding, through the contract are also considered to be "lower tier participants".

After reading the instructions on the next page, the person authorized to submit the model contract and proposal must sign the certification and include it in the proposal package by the due date in the model contract and proposal solicitation letter. Proposals not containing the certification will not be considered for an award.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

1. By signing and submitting this certification as part of this proposal, the prospective lower tier participant, is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances, including but not limited to suspension, debarment, or exclusion from participation in any federally-funded health care program following its previous certification.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction,” without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a `system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS

(1) The prospective lower tier participant certifies, by submitting this proposal and signing below, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or is excluded as the result of state or federal action from participation in any federally-funded health care program.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

_____ _____
Signature Date

_____
Printed Name

_____
Name of Prospective Contractor

ATTACHMENT VI
CONFIDENTIAL RATES OF PAYMENT

This attachment is confidential, and is not open until, at the earliest July 1, 2009. See Exhibit D, Item II.P. of this Agreement for the standards governing confidentiality.

I. HEALTHY FAMILIES PROGRAM RATES

ONE YEAR PREMIUM RATES

Subscriber Child Premium Rates for the July 1, 2005 - June 30, 2006 benefit year

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber Child ages 1 thru 18						

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber Child Under Age One*						

*Plans are to leave infant rates blank. Will be 2.78 times the negotiated rate for children 1-18 years.

TWO YEAR PREMIUM RATES

Subscriber Child Premium Rates for the July 1, 2005 - June 30, 2007 benefit years

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber Child ages 1 thru 18						

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber Child Under Age One*						

*Plans are to leave infant rates blank. Will be 2.78 times the negotiated rate for children 1-18 years.

II. SUBSCRIBER CHILD PREMIUM RATE FOR INFANTS BORN TO MOTHERS ENROLLED IN AIM (to be completed only by health plans contracted to provide AIM services)

Lump-sum Rate per AIM-linked Subscriber (covers period from birth through end of month that follows birth month and applies in all geographic areas served by plan)

Rate for July 1, 2005 – June 30, 2006: _____

Rate for July 1, 2005 – June 30, 2007: _____

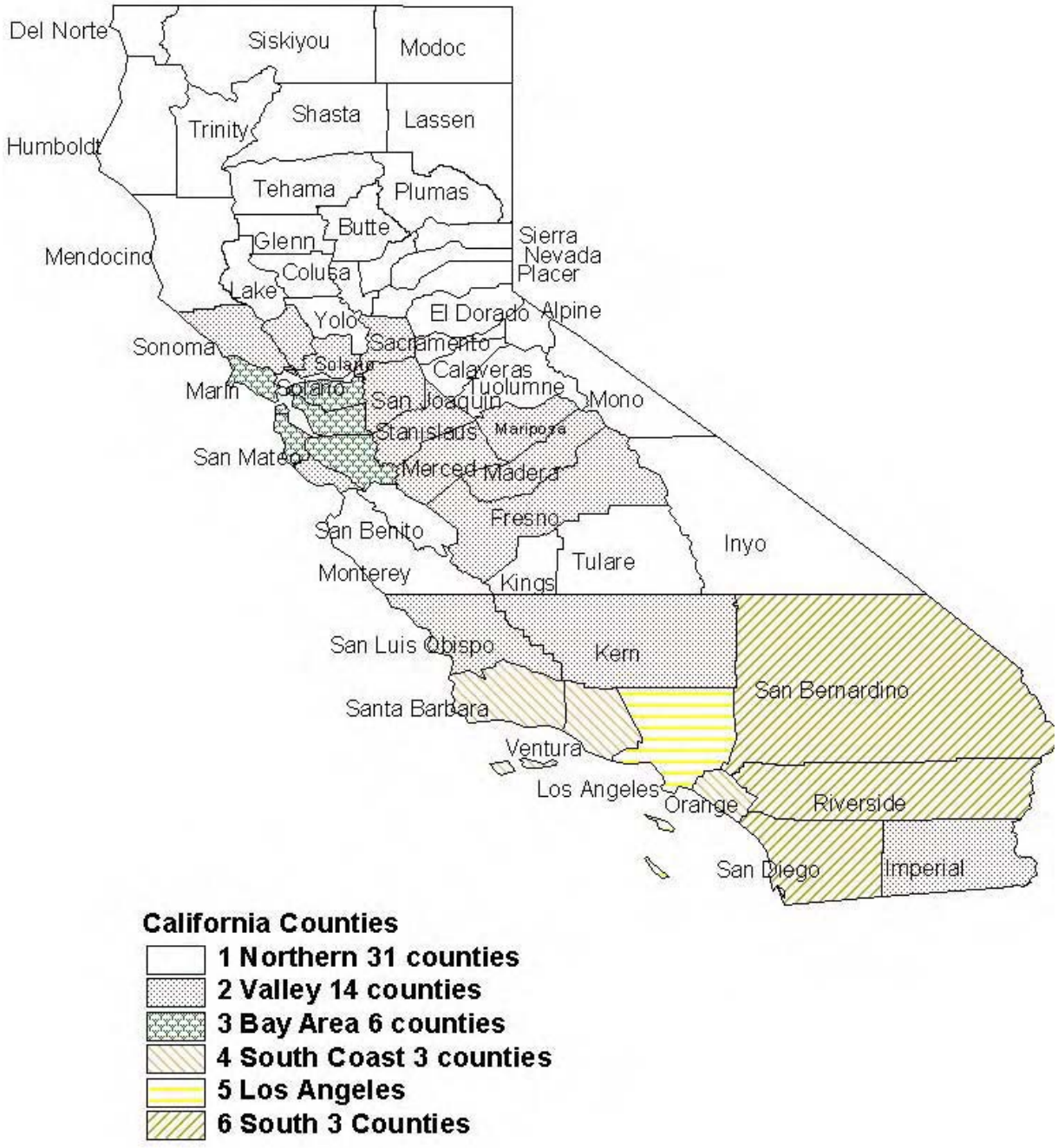
Plan Name _____

Contact Person: _____

Telephone: _____

e-mail : _____

California MRMIB Regions



For a listing of counties in each region, refer to section 2699.6801 of HFP regulations.

Healthy Families Program
Evidence of Coverage (EOC) or Certificate of Insurance (COI) Instructions

Following is a timeline for submitting Healthy Families Program (HFP) documents.

DATE	DOCUMENT(S)
December 10, 2004	Plan is required to send draft copies of the Plan's 2005-06 EOC/COI booklet to MRMIB **and** DMHC for review and approval.
March 1, 2005	Plan is required to send a draft copy of the letter to MRMIB for review and approval, if Plan intends to send a letter to members by April 1, 2005, describing the 2005-06 benefit changes.
April 1, 2005	Plan is required to mail to members an updated Provider Directory and either: • a final 2005-06 EOC/COI, or • a letter describing the 2005-06 benefit changes.
June 15, 2005	If Plan did not mail the final 2005-06 EOC/COI to members by April 1, 2005, it must mail the EOC/COI to members by June 15, 2005.
July 1, 2005	Plan must mail five final, bound EOCs/COIs (**not copies**) and one copy of the updated Provider Directory to: Dinorah Torza Benefits and Quality Monitoring Division Managed Risk Medical Insurance Board 1000 G Street, Suite 450 Sacramento, CA 95814.
September 30, 2005	Plan must mail copies of the member packet that have been translated into different languages to Dinorah Torza at the above address. Please refer to Exhibit A, Section III.C.2.c. of the HFP Model Contract for further details.

MRMIB has developed a Model EOC/COI with standardized language for use by plans (see Attachment VII - Part 2). MRMIB strongly encourages plans to adopt the Model EOC/COI. Please note that many sections in the Model EOC/COI allow a plan to insert its own language. A plan may also revise the non-mandatory sections to fit its current procedures, although the description of benefits in the EOC/COI must be consistent with the HFP regulations.

MRMIB requests that each plan forward its draft 2005/06 EOC/COI to MRMIB with the following information:

FOR NEW AND PARTICIPATING PLANS THAT ADOPT THE MODEL EOC/COI

A plan must use the mandatory language contained in the Disclosure, Eligibility and Enrollment, Accessing Care, and Coordination of Services sections described below. A plan should insert the plan's language in the sections without standardized language and it may revise the **non-mandatory** standardized sections by underlining the text that the plan adds and striking-out the deleted text. Additionally, the plan must prepare a separate document that summarizes the changes made to the standardized language by describing the deletions and additions, identifying the relevant page numbers, and explaining the plan's reasons for making the changes.

FOR PARTICIPATING PLANS THAT DO NOT ADOPT THE MODEL EOC/COI

Using the plan's 2004-05 EOC/COI as the base, the plan should prepare the draft 2005-06 EOC/COI by striking out text proposed for deletion and underlining text proposed for addition to the current EOC/COI. The plan must use the mandatory language contained in the Disclosure, Eligibility and Enrollment, Accessing Care, and Coordination of Services sections described below. Additionally, the Plan must prepare a separate document that summarizes the changes made to the 2004-05 EOC/COI by describing the deletions and additions, identifying the relevant page numbers, and explaining the plan's reasons for making the changes.

FOR NEW PLANS THAT DO NOT ADOPT THE MODEL EOC/COI

The plan's EOC/COI should contain the following sections:

Front Cover

The cover of the EOC/COI Booklet should include the name of the plan and the Healthy Families Program logo and the benefit year. To obtain a 2"X 3½" camera ready Healthy Families Program logo, please contact Dinorah Torza at Dtorza@mrmib.ca.gov or (916) 323-2072.

Body of the Document

All HFP EOCs/COIs should: 1) be prepared in compliance with the standards of the Plan's regulatory agency, 2) be consistent with Article 3 of the HFP regulations, and 3) contain the headings and topics listed below.

On the first or second page, you must include the following paragraphs:

Disclosure

Note: The language contained in the HFP Model EOC/COI is mandatory and must be included in the EOC/COI.

Eligibility and Enrollment

Note: The language contained in the HFP Model EOC/COI is mandatory and must be included in the EOC/COI.

Section 1: Introduction

About the Health Plan

Please describe key features about the Plan; including the Plan's service area, customer service number, and other important information.

Multilingual Services

Please describe how language support services may be accessed by non-English proficient members.

Member Identification Card

Please describe how members should use their member identification card.

Section 2: Definitions

Please include the definition of terms used in the EOC/COI

Section 3: Member Rights and Responsibilities

Please describe members' rights and responsibilities concerning their health care services.

Section 4: Accessing Care

Note: The language contained in the HFP Model EOC/COI is mandatory and must be included in the EOC/COI.

Section 5: Using the Health Plan

Please include the following subsections:

Facilities and Provider Locations
Choosing Your Primary Care Provider
Scheduling Appointments
Initial Health Exam
Changing Your Provider
Continuity of Care for New Members
Continuity of Care for Termination of Provider
Prior Authorization for Services
Referrals to Specialty Physicians
Obtaining a Second Opinion
Utilization Review
Getting Pharmacy Benefits
Getting Urgent Care
Emergency Health Care Services
What To Do If You Are Not Sure If You Have An Emergency
Follow-up Care

Non-Covered Services
Copayments
Member Liabilities

Section 6: Health Plan Covered Benefits Matrix

Please include a chart which summarizes the benefits provided under the Healthy Families Program.

Section 7: Benefit Descriptions

Please include a detailed description of the HFP benefits, including copayments. The description must be consistent with the HFP regulations and define the following benefits:

Inpatient Hospital Services
Outpatient Hospital Services
Professional Services
Preventive Health Service
Diagnostic X-Ray and Laboratory Services
Diabetic Care
Prescription Drug Program
Durable Medical Equipment
Orthotics and Prosthetics
Cataract Spectacles and Lenses
Maternity Care
Family Planning Services
Medical Transportation Services
Emergency Health Care Services
Inpatient Mental Health Services
Outpatient Mental Health Services
Inpatient Alcohol/Drug Abuse Services
Outpatient Alcohol/Drug Abuse Services
Home Health Care Services
Skilled Nursing Care
Physical, Occupational, and Speech Therapy
Acupuncture (Optional)
Chiropractic Services (Optional)
Biofeedback (Optional)
Blood and Blood Products
Health Education
Hospice
Organ Transplants
Reconstructive Surgery
Phenylketonuria (PKU)
Clinical Cancer Trials
Annual or Lifetime Benefit Maximums

Section 8: Coordination of Services

California Children's Services (CCS)
Note: The language contained in the HFP Model EOC/COI is mandatory and must be included in the EOC/COI.

County Mental Health Benefits for Serious Emotional Disturbance Children (SED)
Note: The language contained in the HFP Model EOC/COI is mandatory and must be included in the EOC/COI.

Section 9: Excluded Benefits
Please include a detailed description of exclusions and limitations. The description must be consistent with the HFP regulations.

Section 10: Grievance and Appeals Process
Please include the following subsections:
- Grievance
- Independent Medical Reviews
- Independent Medical Review for Denials of Experimental/ Investigational Therapies
- Review by the Department of Managed Health Care
- Arbitration

Section 11: General Information
This section should include information about:
- Other Health Insurance
- Third Party Recovery Process and Member Responsibilities
- Non-Duplication of Benefits with Workers' Compensation
- Coordination of Benefits
- Limitations of Other Coverage
- Provider Payment
- Reimbursement Provisions – If You Receive a Bill
- Public Participation
- Notifying You of Changes in the Plan
- Privacy Practices
- Organ and Tissue Donation

Back Cover (or inside back cover)
Please provide a map of the plan's licensed service area.

(Insert Plan Name)

Combined Evidence of Coverage and Disclosure Form
July 1, 2005 to June 30, 2006

(Insert Healthy Families Program Logo)

Disclosure

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Health Plan's policies and coverage under the Healthy Families Program (HFP). The Health Plan contract and the HFP regulations (California Code of Regulations, Title 10, Chapter 5.8) issued by the California Managed Risk Medical Insurance Board (MRMIB), should be consulted to determine the exact terms and conditions of coverage. These regulations may be viewed on the Internet at http://www.mrmib.ca.gov.

Additionally, the HFP regulations require the Health Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage booklet or the Health Plan contract.

Eligibility and Enrollment

Information about eligibility, enrollment, disenrollment, the starting date of coverage, transfers to another health plan, annual requalification, premium payments, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) is included in the Healthy Families Program Handbook that was mailed to you by the Healthy Families Program. If you have questions on these topics or would like another copy of the Handbook, please contact the Healthy Families Program at the following address or toll-free telephone number:

Healthy Families Program
P.O. Box 138005
Sacramento, CA 98513-8005
(800) 880-5305
The hearing impaired should call the California Relay Service at 711(TTY).

Additional information about the Health Families Program is available at the Managed Risk Medical Insurance Board Website at www.mrmib.ca.gov.

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Introduction

Using This Booklet

This booklet, called the Combined Evidence of Coverage and Disclosure Form or "EOC", contains detailed information about Healthy Families Program benefits, how to obtain benefits, and the rights and responsibilities of Healthy Families Program members. Please read this booklet carefully and keep it on hand for future reference. If you have special health care needs, please carefully read the sections that apply to you.

Throughout this booklet, "you," "your," and "member" refers to the child or children enrolled in the Healthy Families Program. "We," "us," and "our" refers to Insert Plan Name. "Provider," "plan provider," or "participating provider" refers to a licensed physician, hospital, medical group, pharmacy, or other health care provider who is responsible for providing medical services to you.

Welcome! About the Health Plan

[Language to be provided by the Plan: Please describe key features about the health plan, including the plan's service area, customer service number, and other important information.]

Multilingual Services

If you or your representative prefer to speak in any language other than English, call us at Insert Number (TDD/TTY for the hearing impaired at Insert Number) to speak with a Insert Plan Name Member Services Representative. Our Member Services staff can help you find a health care provider who speaks your language or who has a regular interpreter available. You do not have to use family members or friends as interpreters. If you cannot locate a health care provider who meets your language needs, you can request to have an interpreter available for discussions of medical information at no charge.

This EOC booklet, as well as other informational material, has been translated into [please list the languages.] To request translated materials, please call Insert Plan Name's Member Services at Insert Number (TDD/TTY for the hearing impaired at Insert Number).

Member Identification Card

All members of Insert Plan Name are given a member identification card. This card contains important information regarding your medical benefits. If you have not received or if you have lost your member identification card, please call us at Insert Number (TDD/TTY for the hearing impaired at Insert Number) and we will send you a new card. Please show your Insert Plan Name member identification card to your provider when you receive medical care or pick up prescriptions at the pharmacy.

Only the member is authorized to obtain medical services using his or her member identification card. If a card is used by or for an individual other than the member, that individual will be billed for the services he or she receives. Additionally, if you let

someone else use your member identification card, Insert Health Plan may not be able to keep you in our plan.

Definitions

Acute Condition
A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Authorization
The requirement that certain services be approved by Insert Plan Name or your Primary Care Provider before being provided in order to be a covered service.

Benefits (Covered Services)
Those services, supplies, and drugs that a member is entitled to receive pursuant to the terms of this Agreement. A service is not a benefit, even if described as a covered service or benefit in this booklet, if it is not medically necessary or if it is not provided by a Insert Plan Name provider with authorization as required.

Benefit Year
The twelve (12) month period commencing July 1 of each year at 12:01 a.m.

Copayment
A fee, which the Plan provider may collect directly from a member, for a particular covered benefit at the time the service is rendered.

Emergency Care
An emergency is a medical or psychiatric condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Place the patient's health in serious jeopardy
- Cause serious impairment to bodily functions
- Cause serious dysfunction of any bodily organ or part

Exclusion
Any medical, surgical, hospital or other treatment for which the program offers no coverage.

Experimental or Investigational Service
Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

Evidence of Coverage and Disclosure Form (EOC)
This booklet is the combined Evidence of Coverage and Disclosure Form that describes your coverage and benefits.

Formulary
A list of brand-name and generic prescription drugs approved for coverage and available without prior authorization from Insert Plan Name. The presence of a prescription drug on the formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Grievance
A written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a member or the member's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Healthy Families
The state program administered by MRMIB to provide medical, dental and vision coverage to children who meet the eligibility and income requirements and contribute a monthly family contribution.

Hospital
A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either: (a) an acute care hospital; (b) a psychiatric hospital; or (c) a hospital operated primarily for the treatment of alcoholism and/or substance abuse. A facility which is primarily a rest home, nursing home or home for the aged, or a distinct part skilled nursing facility portion of a hospital is not included.

Inpatient
An individual who has been admitted to a hospital as a registered bed patient and receives covered services under the direction of a physician.

Managed Risk Medical Insurance Board (MRMIB)
The State agency that administers the Healthy Families Program.

Medically Necessary
Those health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply and level of service which considers the potential risks, benefits and alternatives.

Member
A person who joins Insert Plan Name to receive his or her health care. In this booklet, a member is also referred to as “you.”

Member Identification Card
The identification card provided to members by Insert Plan Name that includes the member number, primary care provider information, and important phone numbers.

Non-formulary Drug
A drug that is not listed on Insert Plan Name's Formulary and requires an authorization from Insert Plan Name in order to be covered.

Non-Participating Provider
A provider who has not contracted with Insert Plan Name to provide services to members.

Mental Health Services
Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage and family therapist, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with an illness, injury, or any other condition.

Orthotic Device
A support or brace designed for the support of a weak or ineffective joint, muscle, or to improve the function of movable body parts.

Outpatient
Services, under the direction of a physician, which do not incur overnight charges at the facility where the services are provided.

Out-of Area Services
Emergency care or urgent care provided outside of Insert Plan Name's service area which could not be delayed until member returned to the service area.

Plan
Insert Plan Name

Plan Physician
A doctor of medicine or osteopathy rendering a service covered under this EOC, licensed in the state or jurisdiction of practice, and practicing within the scope of his or her license, who has entered into a written agreement with Insert Plan Name to provide covered services to members in accordance with the terms of this agreement.

Participating Provider or Plan Provider
A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency who, or which, at the time care is rendered to a member, has a contract in effect with Insert Plan Name to provide covered services to its members.

Primary Care Provider (PCP)

A pediatrician, general practitioner, family practitioner, internist, or sometimes an obstetrician/gynecologist, who has contracted with Insert Plan Name or works at a clinic contracted with Insert Plan Name to provide primary care to members and to refer, authorize, supervise and coordinate the provision of benefits to members in accordance with the Evidence of Coverage booklet. Nurse practitioners and physician assistants associated with a contracted primary care provider are available to members seeking primary care.

Program
The Healthy Families Program.

Prosthetic Device
An artificial device used to replace a body part.

Provider
A physician, hospital, skilled nursing facility or other licensed health professional, licensed facility or licensed home health agency.

Provider Directory - The directory of all the providers contracted with Insert Plan Name to provide services to its members.

Serious Chronic Condition
A medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Service Area
[Plan to provide the language. Please describe the Plan's service area.]

Skilled Nursing Facility
A facility licensed by the California State Department of Health Services as a "Skilled Nursing Facility" to provide a level of inpatient nursing care that is not of the intensity required of a hospital.

Specialist Physician
A plan physician who provides services to a member usually upon referral by a primary care provider within the range of his or her designated specialty area of practice and who is specialty board certified or specialty board eligible in such specialty. Some specialty services do not require a referral, e.g., obstetrical services.

Terminal Illness
An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.

Urgent Care
Services need to prevent serious deterioration of a member's health resulting from unforeseen illness or injury for which treatment cannot be delayed.

Member Rights and Responsibilities

As a (Insert Plan Name) member, you have the right to:

- Be treated with respect and dignity.
- Choose your primary care provider from our Provider Directory.
- Get appointments within a reasonable amount of time.
- Participate in candid discussions and decisions about your health care needs, including appropriate or medically necessary treatment options for your condition(s), regardless of cost and regardless of whether the treatment is covered by this health plan.
- Have a confidential relationship with your provider.
- Have your records kept confidential. This means we will not share your health care information without your written approval or unless it is permitted by law.
- Voice your concerns about Insert Plan Name, or about health care services you received, to Insert Plan Name.
- Receive information about Insert Plan Name, our services, and our providers.
- Make recommendations about your rights and responsibilities.
- See your medical records.
- Get services from providers outside of our network in an emergency.
- Request an interpreter at no charge to you.
- Use interpreters who are not your family members or friends.
- File a complaint if your linguistic needs are not met.

Your responsibilities are to:

- Give your providers and Insert Plan Name correct information.
- Understand your health problem(s) and participate in developing treatment goals, as much as possible, with your provider.
- Always present your Member Identification Card when getting services.
- Use the emergency room only in cases of an emergency or as directed by your provider.
- Make and keep medical appointments and inform your provider at least 24 hours in advance when an appointment must be cancelled.
- Ask questions about any medical condition and make certain you understand your provider's explanations and instructions.
- Help Insert Plan Name maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health care coverage.
- Notify Insert Plan Name as soon as possible if a provider bills you inappropriately or if you have a complaint.
- Treat all Insert Plan Name personnel and health care providers respectfully and courteously.

Accessing Care

Physical Access

Insert Plan Name has made every effort to ensure that our offices and the offices and facilities of Insert Plan Name providers are accessible to the disabled. If you are not able to locate an accessible provider, please call us toll free at Insert Number and we will help you find an alternate provider.

Access for the Hearing Impaired

The hearing impaired may contact us through our TDD number at Insert Plan TDD Number, Monday through Friday, from XXa.m. to XXp.m. Between XXp.m. and XX a.m. and on weekends, please call the California Relay Service TTY at 711 to get the help you need.

Access for the Vision Impaired

This Evidence of Coverage (EOC) and other important plan materials will be made available in [please list the different formats; for example, large print, enlarged computer disk, audiotape, etc.] for the vision impaired. For alternative formats or for direct help in reading the EOC and other materials, please call us at Insert the Plan Number.

The Americans with Disabilities Act of 1990

Insert Plan Name complies with the Americans with Disabilities Act of 1990 (ADA). This Act prohibits discrimination based on disability. The Act protects members with disabilities from discrimination concerning program services. In addition, section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participation in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

Disability Access Grievances

If you believe the plan or its providers have failed to respond to your disability access needs, you may file a grievance with Insert Plan Name by calling Insert Plan Number.

If your disability access complaint remains unresolved, you may contact the:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695
The hearing impaired should call the California Relay Service at 711(TTY).

Using The Health Plan

Facilities and Provider Locations
PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

[Language to be provided by the plan: Please provide information about the plan's health care providers, service area, how members can obtain a Provider and/or Facilities Locations Directory, and other relevant information.]

Choosing a Primary Care Provider
[Language to be provided by the plan: Please describe how members choose a primary care provider, what services the primary care provider provides to members and any information members should consider when choosing a primary care provider.]

Scheduling Appointments
[Language to be provided by the Plan: Please provide information about scheduling, changing, or canceling an appointment and other relevant information.]

Initial Health Exam
All new members are encouraged to see their primary care provider for an initial health examination when they join the Healthy Families Program. The first meeting with your new doctor is important. It's a time to get to know each other and review your health status. Your doctor will help you understand your medical needs and advise you about staying healthy. Call your doctor's office for an appointment today.

Changing Your Primary Care Provider
[Language to be provided by the Plan: Please describe how and when members can change their primary care provider, the effective date of the change, information about how the change may affect a member's ability to access other providers (hospitals, specialist physicians, etc.) and when the plan may need to change a member's primary care provider.]

Continuity of Care for New Members
Under some circumstances, Insert Plan Name will provide continuity of care for new members who are receiving medical services from a non-participating provider, such as a doctor or hospital, when Insert Plan Name determines that continuing treatment with a non-participating provider is medically appropriate. If you are a new member, you may request permission to continue receiving medical services from a non-participating provider if you were receiving this care before enrolling in Insert Plan Name and if you have one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange

for a safe transfer to another provider, as determined by Insert Plan Name in consultation with you and the non-participating provider, and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Insert Plan Name.

- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time you enroll with Insert Plan Name.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Insert Plan Name.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the non-participating provider to occur within 180 days of the time you enroll with Insert Plan Name.

Please contact us at Insert Number to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this plan.

We will request that the non-participating provider agree to the same contractual terms and conditions that are imposed upon participating providers providing similar services, including payment terms. If the non-participating provider does not accept the terms and conditions, Insert Plan Name is not required to continue that provider's services.

[Plan to provide language describing how the plan will notify the member of its decision.] If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see Insert Plan Name's Grievance and Appeals Process on page XXXX.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Continuity of Care for Termination of Provider

If your primary care provider or other health care provider stops working with Insert Plan Name, we will let you know by mail 60 days before the contract termination date.

Insert Plan Name will provide continuity of care for covered services rendered to you by a provider whose participation we have terminated, if you were receiving this care from this provider prior to termination and you have one of the following conditions:

- An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Insert Plan Name in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- A pregnancy, including postpartum care. Completion of covered services shall be provided for the duration of the pregnancy.
- A terminal illness. Completion of covered services shall be provided for the duration of the terminal illness. Completion of covered services may exceed twelve (12) months from the time the provider stops contracting with Insert Plan Name.
- The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the provider's contract termination date.
- Performance of a surgery or other procedure that Insert Plan Name had authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with Insert Plan Name prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, we are not required to continue the provider's services beyond the contract termination date.

Please contact us at Insert Number to request continuing care or to obtain a copy of our Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. Continuity of care does not provide coverage for benefits not otherwise covered under this agreement. If your request is approved, you will be financially responsible only for applicable copayments under this plan.

[Plan to provide language describing how the plan will notify the member of it decision.] If we determine that you do not meet the criteria for continuity of care and you disagree with our determination, see Insert Plan Name's Grievance and Appeals Process on page XXXX.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Prior Authorization for Services

Your primary care provider will coordinate your health care needs and, when necessary, will arrange specialty services for you. In some cases, Insert Plan Name must authorize the specialty services before you receive the services. Your primary care provider will obtain the necessary referrals and authorizations for you. Some specialty services, such as OB/GYN services, do not require prior authorization before you receive the services.

If you see a specialist or receive specialty services before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If Insert Plan Name denies a request for specialty services, Insert Plan Name will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals to Specialty Physicians

Your primary care provider may decide to refer you to a physician who is a specialist to receive care for a specific medical condition. For most covered services not directly provided by your primary care provider; including specialty, non-emergency hospital, laboratory and x-ray services; the services must be authorized in advance by your primary care provider. In consultation with you, your primary care provider will choose a participating specialist physician, participating hospital, or other participating provider from whom you may receive services. For a list of specialists, call Member Services at Insert Number (TDD/TTY for the hearing impaired at Insert Number).

In the event that there is no participating provider available to perform the needed service, your primary care provider will refer you to a non-participating provider for the services, after obtaining authorization from Insert Plan Name.

If you have a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling, you may need to see a specialist for an extended period of time. You can get a standing referral to a specialist for this time period. This means you will not need to get authorization every time you see that specialist. To get a standing referral, call your primary care provider. Upon approval by Insert Plan Name, you may contact Insert Plan Name to request a list of participating providers who have demonstrated expertise in treating the condition or disease for which you have been given a standing referral. If you have any difficulty getting a standing referral, call Insert Plan Name at Insert Number (TDD/TTY for the hearing impaired at Insert Number). If after calling the plan you feel that your needs have not been met, please refer to Insert Plan Name's Grievance and Appeals Process on page XXX.

If you see a specialist or receive specialty services before you receive the required referral, you will be responsible to pay for the cost of the treatment. If Insert Plan Name denies a request for specialty services, Insert Plan Name will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

This is a summary of Insert Plan Name's specialist referral policy. To obtain a copy of our policy, please contact us at Insert Number.

Obtaining a Second Opinion

Sometimes you may have questions about your illness or your primary care provider's recommended treatment plan. You may want to get a second opinion. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended surgical procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, limb, or bodily function.
- Your provider's advice is not clear, or it is complex and confusing.
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.
- The treatment plan in progress has not improved your medical condition within an appropriate period of time.
- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

You should speak to your primary care provider if you want a second opinion. After you or your primary care provider has requested permission to obtain a second opinion, Insert Plan Name will authorize or deny your request in an expeditious manner. If your medical condition poses an imminent and serious threat to your health, including but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function; your request for a second opinion will be processed within 72 hours after Insert Plan Name receives your request.

If your request to obtain a second opinion is authorized, you must receive services from a plan provider within your medical group. If there is no qualified provider in your medical group, Insert Plan Name will authorize a second opinion from a non-participating provider. You will be responsible for paying all copayments for the second opinion.

If your request to obtain a second opinion is denied and you would like to appeal our decision, please refer to Insert Plan Name's Grievance and Appeals Process on page XX.

This is a summary of Insert Plan Name's policy regarding second opinions. To obtain a copy of our policy, please contact us at Insert Number.

Utilization Review

[Language to be provided by the Plan: Please describe the plan's utilization review process and how members can obtain information regarding the process.]

Getting Pharmacy Benefits

[Language to be provided by the Plan: Please describe the plan's prescription drugs policy. If the plan uses a drug formulary, please include a description of what a formulary is, how the plan determines which prescription drugs are included or excluded, how often the plan reviews the contents of the formulary, how members can receive a copy of the plan's formulary, the plan's policy regarding dispensing generic drugs, how providers can obtain authorization to prescribe a medically necessary nonformulary prescription drug, and how members can appeal the plan's decision to deny a provider's request to prescribe a nonformulary drug. Also, please describe the plan's prescription drug policies regarding off-label use and the availability of discontinued medications.]

Getting Urgent Care

Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, an injury, prolonged pain, or a complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Insert Plan Name covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit, talk to your primary care provider about what he or she wants you to do when the office is closed and you feel urgent care may be needed.

To obtain urgent care when you are **inside** Insert Plan Name's services area on nights and weekends, [plan to provide language describing the process for obtaining urgent care during non-office hours.]

To obtain urgent care when you are **outside** Insert Plan Name's services area, [plan to provide language describing the process for obtaining urgent care when the member is outside the plan's service area.]

Emergency Health Care Services

An emergency is a medical or psychiatric condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to:

- Place your health in serious jeopardy,
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any bodily organ or part.

Examples include:

- Broken bones
- Chest pain
- Severe burns
- Fainting
- Drug overdose
- Paralysis
- Severe cuts that won't stop bleeding
- Psychiatric emergency conditions

If you have a medical emergency, call 911 or go to the nearest emergency room.

Emergency services are covered inside and outside of Insert Plan Name's service area. [Plan to insert language describing how members should inform their primary care provider or the plan if they are admitted to the hospital. Plans should also describe any requirement to have the member transferred to a plan provider for post-stabilization care.]

What to Do If You Are Not Sure If You Have an Emergency

If you are not sure whether you have an emergency or require urgent care [plan to provide language informing the members what they should do if they are not sure if they have an emergency.]

Follow-up Care

After receiving any emergency or urgent care services, you will need to call your primary care provider for follow-up care.

Non-Covered Services

Insert Plan Name does not cover medical services that are received in an emergency or urgent care setting for conditions that are not emergencies or urgent if you reasonably should have known that an emergency or urgent care situation did not exist. You will be responsible for all charges related to these services.

Copayments

You will be required to pay a small amount of money for some services. This is called a copayment. The maximum amount of money you are required to pay out in one benefit year per household is $250. All copayments paid for Healthy Families members in your household apply to the $250 maximum.

Make sure that you keep all receipts from your doctors' visits and prescriptions for all family members enrolled in the Healthy Families Program. As soon as you have paid $250 in a benefit year, [plan to provide language regarding how a family notifies the plan that they have paid $250 in copayments.].

When Insert Plan Name receives your receipts, then no Healthy Families members in your household will have to pay copayments for the rest of the benefit year. You will still need to pay copayments until Insert Plan Name receives proof that you have paid $250.

No copayment will be charged for routine examinations and preventive care. Additionally, no copayment will be charged to members 24 months of age and younger for any covered services. However, you will be charged copayments for prescriptions for members 24 months of age and younger. There are no copayments for members who are determined under Healthy Families Program rules to be American Indians or Alaskan Natives. For information pertaining to copayment waivers for American Indians or Alaskan Natives, please refer to the Healthy Families Program Handbook or contact the Healthy Families Program at (800) 880-5305.

Member Liabilities

Generally, the only amount a member pays for covered services is the required copayment. However, you may be financially responsible for specialty services you receive without obtaining a referral or authorization. You may also be responsible for services you receive that are not covered services; non-emergency services received in the emergency room; non-emergency or non-urgent services received outside of Insert Plan Name's service area without prior authorization; and, unless authorized, services received that are greater than the limits specified in this Evidence of Coverage booklet.

In the event Insert Plan Name does not pay a participating provider for covered services, you will not be liable to the provider for any money owed by Insert Plan Name. However, if Insert Plan Name does not pay a non-participating provider for covered services, you may be liable to the non-participating provider for the cost of the services. You may also be liable for payment of non-covered services, whether received from a participating or non-participating provider.

Health Plan Covered Benefits Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERED BENEFITS AND IS A SUMMARY ONLY. THE BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERED BENEFITS AND LIMITATIONS.

Benefits*	Services	Cost to Member (copayment)
Inpatient Hospital Services	Room and board, nursing care, and all medically necessary ancillary services.	No copayment
Outpatient Hospital Services	Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility.	No copayment except • $5 per visit for physical, occupational and speech therapy performed on an outpatient basis. • $5 per visit for emergency health care services (waived if the member is hospitalized)
Professional Services	Services and consultations by a physician or other licensed health care provider.	$5 per office or home visit except • No copayment for hospital inpatient professional services • No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments • No copayment for members 24 months of age and younger • No copayment for vision or hearing testing, or for hearing aids
Preventive Health Service	Periodic health examinations, routine diagnostic testing and laboratory services, immunizations, and services for the detection of asymptomatic diseases.	No copayment
Diagnostic, X-Ray and Laboratory Services **	Laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, and treat members.	No copayment

Benefits*	Services	Cost to Member (copayment)
Diabetic Care **	Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription.	$5 copayment per office visit
Prescription Drug Program **	Drugs prescribed by a licensed practitioner.	$5 per prescription for a 30-34 day supply for brand name or generic drugs. $5 per prescription for a 90-100 day supply of maintenance drugs • No copayment for prescription drugs provided in an inpatient setting. • No copayment for drugs administered in the doctor's office or in an outpatient facility. • No copayment for FDA-approved contraceptive drugs and devices.
Durable Medical Equipment **	Medical equipment appropriate for use in the home which primarily serves a medical purpose, is intended for repeated use, and is generally not useful to a person in the absence of illness or injury.	No copayment
Orthotics and Prosthetics **	Original and replacement devices as prescribed by a licensed practitioner.	No copayment
Cataract Spectacles and Lenses **	Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.	No copayment
Maternity Care	Professional and hospital services relating to maternity care.	No copayment
Family Planning Services	Voluntary family planning services	No copayment

Benefits*	Services	Cost to Member (copayment)
Medical Transportation Services **	Emergency ambulance transportation and non-emergency transportation to transfer a member from a hospital to another hospital or facility, or facility to home.	No copayment
Emergency Health Care Services **	Emergency services are covered both in and out of the plan's service area and in and out of the plan's participating facilities.	$5 per visit (waived if the member is admitted to the hospital.)
Inpatient Mental Health Services	Confinement in a participating hospital is covered. Care for members determined to have a serious emotional disturbance (SED) condition will be provided by the county mental health department. The member will remain enrolled in the plan and will continue to receive medical care from plan providers for services not related to the SED condition.	No copayment Benefit is limited to 30 days per benefit year, except for the treatment of severe mental illnesses
Outpatient Mental Health Services	Mental health care is covered when services are ordered and performed by a Plan mental health professional. Care for members determined to have a serious emotional disturbance (SED) condition will be provided by the county mental health department. The member will remain enrolled in the plan and will continue to receive medical care from plan providers for services not related to the SED condition.	$5 per visit Benefit is limited to 20 visits per benefit year, except for the treatment of severe mental illnesses
Inpatient Alcohol / Drug Abuse Services	Hospitalization to remove toxic substances from the system.	No copayment
Outpatient Alcohol / Drug Abuse Services	Crisis intervention and treatment of alcoholism or drug abuse.	$5 per visit Benefit is limited to 20 visits per benefit year
Home Health Care Services	Services provided at the home by health care personnel.	No copayment, except • $5 per visit for physical, occupational, and speech therapy

Benefits*	Services	Cost to Member (copayment)
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	No copayment Benefit is limited to a maximum of 100 days per benefit year
Physical, Occupational, and Speech Therapy **	Therapy may be provided in a medical office or other appropriate outpatient setting.	$5 per visit when performed in an outpatient setting No copayment for inpatient therapy
Blood and Blood Products **	Includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings.	No copayment
Health Education	Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.	No copayment
Hospice	For members who are diagnosed with a terminal illness and who elect hospice care instead of traditional health care services.	No copayment
Organ Transplants **	Coverage for organ transplants and bone marrow transplants which are not experimental or investigational.	No copayment
Reconstructive Surgery **	Performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, or disease and are performed to improve function or create a normal appearance.	No copayment
Phenylketonuria (PKU) **	Testing and treatment of PKU.	No copayment
Clinical Cancer Trials	Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and member meets certain requirements.	No copayment

Benefits*	Services	Cost to Member (copayment)
California Children's Services Program (CCS)	CCS is a California medical program that treats children who have certain physically handicapping conditions and who need specialized medical care. Services provided through the CCS Program are coordinated by the county CCS office. If the member's condition is determined to be eligible for CCS services, the member remains enrolled in the Healthy Families Program and continues to receive medical care from plan providers for services not related to the CCS eligible condition. The member will receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers.	No copayment
Acupuncture (optional)	Does not require referral from the member's provider but services must be obtained from a plan provider.	$5 per visit Benefit is limited to 20 visits per benefit year
Chiropractic (optional)	Does not require referral from the member's provider but services must be obtained from a plan provider.	$5 per visit Benefit is limited to 20 visits per benefit year
Biofeedback (optional)	Does not require referral from the member's provider but services must be obtained from a plan provider.	$5 per visit
Deductibles	No deductibles will be charged for covered benefits	
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan	

* Benefits are provided only for services which are medically necessary.

** These services may be covered and paid for by the California Children's Services (CCS) program, if the member is found to be eligible for CCS services.

Benefit Descriptions

Inpatient Hospital Services
Cost to Member
No copayment.

Description
General hospital services received in a room of two or more individuals containing customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Benefit includes all medically necessary ancillary services, including, but not limited to:

- Use of operating room and related facilities
- Intensive care unit and services
- Drugs, medications, and biologicals
- Anesthesia and oxygen
- Diagnostic, laboratory, and x-ray services
- Special duty nursing
- Physical, occupational, and speech therapy
- Respiratory therapy
- Administration of blood and blood products
- Other diagnostic, therapeutic, and rehabilitative services
- Coordinated discharge planning, including the planning of such continuing care as may be necessary

Includes coverage for general anesthesia and associated facility charges in connection with dental procedures, when hospitalization is necessary because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to members under seven (7) years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Insert Plan Name will coordinate the services with the member's dental plan.

Exclusions
Personal or comfort items or a private room in a hospital are excluded unless medically necessary. Services of dentists or oral surgeons are excluded for dental procedures.

Outpatient Hospital Services
Cost to Member
No copayment, except:

- $5 per visit for physical, occupational and speech therapy performed on an outpatient basis.
- $5 per visit for emergency health care services, which is waived if the member is hospitalized.

Description
Diagnostic, therapeutic, and surgical services performed at a hospital or outpatient facility including:

- Physical, speech, and occupational therapy as appropriate
- Hospital services which can reasonably be provided on an ambulatory basis
- Related services and supplies in connection with outpatient services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the member's stay at the facility

General anesthesia and associated facility charges and outpatient services in connection with dental procedures when the use of a hospital or surgery center is required because of an underlying medical condition or clinical status, or because of the severity of the dental procedure. This benefit is only available to members under seven (7) years of age; the developmentally disabled, regardless of age; and members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Insert Plan Name will coordinate the services with the member's participating dental plan.

Exclusions
Services of dentists or oral surgeons are excluded for dental procedures.

Professional Services
Cost to Member

- $5 per office or home visit
- No copayment for hospital inpatient professional services
- No copayment for surgery, anesthesia, or radiation, chemotherapy, or dialysis treatments
- No copayment for members 24 months of age or younger
- No copayment for vision or hearing testing, or for hearing aids

Description
Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Professional services include:

- Surgery, assistant surgery, and anesthesia (inpatient or outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment
- Home visits when medically necessary
- Eye examinations including eye refractions to determine the need for corrective lenses and dilated retinal eye exams
- Hearing tests, hearing aids and related services including audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid
- Hearing aid(s): Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. There is no charge for visits for fitting, counseling, adjustments, repairs, etc., for a one-year period following receipt of a covered hearing aid.

Exclusions
- Purchase of batteries or other ancillary equipment, except those covered under the initial hearing aid purchase, and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids or repair of hearing aid after the covered one-year warranty period
- Replacement of a hearing aid more than once in any period of thirty-six months
- Surgically implanted hearing devices

Preventive Health Service
Cost to Member
No copayment

Description
Periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; and age appropriate immunizations, including immunizations required for travel, consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, as adopted by the Advisory Committee on Immunization Practices.

Preventive services also include services for the detection of asymptomatic diseases, including, but not limited to:
- Well-baby care during the first two (2) years of life, including newborn hospital visits, health examinations, and other office visits
- A variety of voluntary family planning services
- Contraceptive services
- Prenatal care
- Vision and hearing testing
- Sexually transmitted disease (STD) testing
- Cytology examinations on a reasonable periodic basis
- Yearly exams (pelvic exam, Pap smear, and breast exam) and any other gynecological service from your primary care provider or an OB/GYN provider in our plan (primary care provider approval not required).
- Medically accepted cancer screening tests including, but not limited to breast, prostate, and cervical cancer screening
- Effective health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan

Limitations
The frequency of periodic health examinations will not be increased for reasons which are unrelated to the member's medical needs, including a member's desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Diagnostic X-Ray and Laboratory Services

Cost to Member

No copayment

Description

Diagnostic laboratory services, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat and follow-up on the care of members. Benefit includes other diagnostic services, including, but not limited to:

- Electrocardiography, electroencephalography, and mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin)

Diabetic Care

Cost to Member

- $5 Copayment per office visit
- Copayments for prescriptions as described in the "Prescription Drug Program" Section below

Description

Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription, including:

1. Blood glucose monitors and blood glucose testing strips
2. Blood glucose monitors designed to assist the visually impaired
3. Insulin pumps and all related necessary supplies
4. Ketone urine testing strips
5. Lancets and lancet puncture devices
6. Pen delivery systems for the administration of insulin
7. Podiatric services to prevent or treat diabetes-related complications
8. Insulin syringes
9. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
10. Insulin
11. Prescriptive medications for the treatment of diabetes
12. Glucagon

Coverage also includes outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications and as prescribed by the member's Insert Plan Name provider.

Prescription Drug Program

Cost to Member

- No copayment for prescription drugs provided in an inpatient setting
- No copayment for drugs administered in the doctor's office or in an outpatient facility setting during the member's stay at the facility

- No copayment for FDA-approved contraceptive drugs and devices, including Norplant
- $5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including tobacco use cessation drugs
- $5 per 90-100 day supply of maintenance drugs supplied through the plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Description

Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes, but is not limited to:

- Injectable medication, and needles and syringes necessary for the administration of the covered injectable medication
- Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin
- Blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent, and gestational diabetes
- Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription
- Medically necessary drugs administered while a member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan-designated pharmacy
- One cycle or course of treatment of tobacco cessation drugs per benefit year. The member must attend tobacco cessation classes or programs in conjunction with the use of tobacco cessation drugs
- All FDA-approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered, including internally implanted time-release contraceptives such as Norplant

For information concerning Insert Plan Name*'s* prescription drug coverage, please refer to "*Getting Pharmacy Benefits*" on page xxx of this booklet.

Exclusions

- Drugs or medications prescribed solely for cosmetic purposes
- Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by your doctor
- Medicines not requiring a written prescription (except insulin and smoking cessation drugs as previously described)
- Dietary supplements (except for formulas or special food products, when medically necessary, including for phenylketonuria or PKU), appetite suppressants, or any other diet drugs or medications, unless medically necessary for the treatment of morbid obesity
- Experimental or investigational drugs.

If Insert Plan Name denies your request for prescription drugs based on a determination that the drug is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to Insert Plan Name's Grievance and Appeals Process on page XX.

Durable Medical Equipment

Cost to Member
No copayment

Description
Medical equipment appropriate for use in the home which

1. Primarily serves a medical purpose,
2. Is intended for repeated use, and
3. Is generally not useful to a person in the absence of illness or injury

Insert Plan Name may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Durable medical equipment includes, but is not limited to:

- Oxygen and oxygen equipment
- Blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes
- Insulin pumps and all related necessary supplies
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin
- Apnea monitors
- Podiatric devices to prevent or treat diabetes complications
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, related supplies, spacer devices for metered dose inhalers, and peak flow meters
- Ostomy bags and urinary catheters and supplies

Exclusions

- Comfort or convenience items
- Disposable supplies, except ostomy bags, urinary catheters, and supplies consistent with Medicare coverage guidelines
- Exercise and hygiene equipment
- Experimental or research equipment
- Devices not medical in nature, such as sauna baths and elevators, or modifications to the home or automobile
- Deluxe equipment
- More than one piece of equipment that serves the same function

Orthotics and Prosthetics

Cost to Member
No copayment

Description
Orthotics and prosthetics benefits include original and replacement devices, including, but not limited to:

- Medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure
- Medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license
- Initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy
- Therapeutic footwear for diabetics
- Prosthetic devices to restore and achieve symmetry incident to mastectomy

Covered items must be prescribed by a physician, authorized by Insert Plan Name, and dispensed by a plan provider. Repairs are provided unless necessitated by misuse or loss. Insert Plan Name, at its option, may replace or repair an item.

Exclusion

- Corrective shoes, shoe inserts, and arch supports, except for therapeutic footwear and inserts for individuals with diabetes
- Non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts
- Dental appliances
- Electronic voice producing machines
- More than one device for the same part of the body
- Eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery)

Cataract Spectacles and Lenses
Cost to Member
No copayment

Description
Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Benefits also include one pair of conventional eyeglasses or conventional contact lenses, if necessary, after cataract surgery with insertion of an intraocular lens.

Maternity Care
Cost to Member
No copayment

Description
Medically necessary professional and hospital services relating to maternity care are covered including:

- Prenatal and postpartum care, including complications of pregnancy
- Newborn examinations and nursery care while the mother is hospitalized

- Coverage includes participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy
- Counseling for nutrition, health education and social support needs
- Labor and delivery care, including midwifery services

Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by cesarean section, unless an extended stay is authorized by the Insert Plan Name. You do not need specific authorization to stay in the hospital 48 hours after a vaginal delivery or 96 hours after a C-section and you may remain in the hospital for these time periods unless you and your doctor decide otherwise. If, after consulting with you, your doctor decides to discharge you before the 48- or 96-hour time period, Insert Plan Name will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor's office depending on the best solution for you.

Family Planning Services
Cost to Member
No copayment

Description
Voluntary family planning services are covered, including:
- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Diaphragms
- Coverage for other federal Food and Drug Administration approved devices pursuant to the prescription drug benefit
- Voluntary Termination of Pregnancy

Note: Some hospitals and other providers do not provide one or more of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective doctor, medical group, independent practice association, clinic, or Insert Plan Name at Insert Number (TDD/TTY for the hearing impaired at Insert Number) to ensure that you can obtain the health care services that you need.

Medical Transportation Services
Cost to Member
No copayment

Description
Emergency ambulance transportation to the first hospital which actually accepts the member for emergency care is covered in connection with emergency services. Benefit includes ambulance and ambulance transport services provided through the "911" emergency response system. Also includes, non-emergency transportation for the transfer of a member from a hospital to another hospital or facility, or facility to home when the transportation is:

- Medically necessary, and
- Requested by a Plan provider, and
- Authorized in advance by Insert Plan Name.

Exclusion
Coverage for transportation by airplane, passenger car, taxi, or other forms of public conveyance.

Emergency Health Care Services
Cost to Member
$5 per visit. Copayment will be waived if the member is admitted to the hospital.

Description
Twenty-four hour emergency care is covered for a medical or psychiatric condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the member's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Coverage is provided both inside and outside of Insert Plan Name's service area, and in participating and non-participating facilities.

Inpatient Mental Health Services
Cost to Member
No copayment

Description
Mental health care during a certified confinement in a participating hospital when ordered and performed by a plan mental health provider for the treatment of a mental health condition.

For members with a Serious Emotional Disturbance (SED), the plan will provide up to 30 days of inpatient services, including related professional services. After 30 days, the responsibility for providing inpatient and related professional services to the member will then transfer to the county mental health department. This transfer may require the SED member to be transferred to a different inpatient facility and a different treating provider. The plan will coordinate care with the county for SED benefits.

Limitation
Inpatient mental health care is limited to thirty (30) days per benefit year. With the agreement of the member, or the member's legal guardian or other responsible adult if appropriate, any of the following may be substituted for each day of inpatient care:

- Two (2) days of residential treatment,
- Three (3) days of day care treatment, or
- Four (4) outpatient visits.

Exception
Inpatient mental health care days for the treatment of severe mental illnesses (SMI) are not limited. Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Outpatient Mental Health Services
Cost to Member
$5 per visit

Description
Mental health care services when ordered and performed by a plan mental health provider. Outpatient mental health benefits include:

- Treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement
- Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the member
- Treatment for severe mental illnesses (SMI), which include, but are not limited to:
  - Schizophrenia
  - Schizoaffective disorder
  - Bipolar disorder (manic-depressive illness)
  - Major depressive disorders
  - Panic disorder
  - Obsessive-compulsive disorder
  - Pervasive developmental disorder or autism
  - Anorexia nervosa
  - Bulimia nervosa

For members with a Serious Emotional Disturbance (SED), outpatient and related professional services pertaining to the SED condition will be provided by the county mental health department. Insert Plan Name will coordinate care with the county mental health department for SED benefits. The member will remain enrolled in Insert Plan Name and will continue to receive primary care, specialty care, and all other covered services from Insert Plan Name for medical conditions not related to the SED condition. For more information about SED diagnosis and treatment benefits, see "Coordination of Services" on page XXX.

Limitations
Outpatient mental health care is limited to twenty (20) visits per benefit year, except that the number of treatment days may be increased when outpatient treatment days are substituted for inpatient hospitalization days as described above in ***Inpatient Mental Health Services***.

Exception
Outpatient mental health care days for the treatment of severe mental illnesses (SMI) are not limited.

Inpatient Alcohol/Drug Abuse Services
Cost to Member
No copayment

Description
Hospitalization for alcoholism or drug abuse as medically necessary to remove toxic substances from the system.

Outpatient Alcohol/Drug Abuse Services
Cost to Member
$5 per visit

Description
Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically necessary.

Limitation
Twenty (20) visits per benefit year. Additional visits may be covered if approved and authorized by Insert Plan Name.

Home Health Care Services
Cost to Member
No copayment, except for $5 per visit for physical, occupational, and speech therapy performed in the home.

Description
Health services provided at home by health care personnel. Benefit includes:

- Visits by RNs, LVNs, and home health aides
- Physical therapy, occupational therapy, and speech therapy

- Respiratory therapy when prescribed by a licensed plan provider acting within the scope of his or her licensure

Limitations
- Home health care services are limited to those services that are prescribed or directed by the member's primary care provider or another appropriate authority designated by Insert Plan Name
- If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the member's primary care provider or other appropriate authority designated by Insert Plan Name to choose the setting for providing the care
- Insert Plan Name will exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting

Exclusion
Custodial care

Skilled Nursing Care
Cost to Member
No copayment

Description
Medically necessary services prescribed by a plan provider and provided in a licensed skilled nursing facility. Benefit includes:
- Skilled nursing on a 24-hour per day basis
- Bed and board
- X-ray and laboratory procedures
- Respiratory therapy
- Physical, speech, and occupational therapy
- Medical social services
- Prescribed drugs and medications
- Medical supplies
- Appliances and equipment ordinarily furnished by the skilled nursing facility

Limitation
This benefit is limited to a maximum of one hundred (100) days per benefit year

Exclusion
Custodial care

Physical, Occupational, and Speech Therapy
Cost to Member
No copayment for inpatient therapy, including services received in a skilled nursing facility
$5 per visit when performed in the home or other outpatient setting

Description
Therapy must be medically necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. Insert Plan Name may require periodic evaluations as long as therapy is provided.

Acupuncture (Optional)
Cost to Member
$5 per visit

Description
Acupuncture services do not require a referral from the member's primary care provider or other health care provider. Services must be obtained from a participating provider.

Limitation
Treatment is limited to a maximum of twenty (20) visits per benefit year

Chiropractic Services (Optional)
Cost to Member
$5 per visit

Description
Chiropractic services do not require a referral from the member's primary care provider or other health care provider. Services must be obtained from a participating provider.

Limitation
Treatment is limited to a maximum of twenty (20) visits per benefit year

Biofeedback (Optional)
Cost to Member
$5 per visit

Description
[Language Provided by Plan.]

Blood and Blood Products
Cost to Member
No copayment

Description
Benefit includes processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Also includes the collection and storage of autologous blood when medically indicated.

Health Education
Cost to Member
No copayment

Description
Effective health education services, including education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

Hospice
Cost to Member
No copayment

Description
The hospice benefit is provided to members who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan. The hospice benefit includes:

- Nursing care
- Medical social services
- Home health aide services
- Physician services, drugs, medical supplies and appliances
- Counseling and bereavement services
- Physical, occupational, and speech therapy
- Short-term inpatient care
- Pain control and symptom management
- *[At the option of the Plan]* Homemaker services, services of volunteers, and short-term inpatient respite care

The hospice election may be revoked at any time

Limitation
Members who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect.

Organ Transplants
Cost to Member
No copayment

Description
Benefits include coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational. The benefit includes payment for:

- Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor, if these expenses are directly related to the transplant for a member
- Testing member's relatives for matching bone marrow transplants
- Searching for and testing unrelated bone marrow donors through a recognized Donor Registry

- Charges associated with procuring donor organs through a recognized Donor Transplant Bank are covered if the expenses are directly related to the anticipated transplant of the member

These services may be covered and paid for by the California Children's Services (CCS) program, instead of by Insert Plan Name, if the member is found to be eligible for CCS services. Insert Plan Name will coordinate these services with CCS for the member. For more information about the CCS program, see "Coordination of Services" on page XXX.

If Insert Plan Name denies your organ transplant request based on a determination that the service is experimental or investigational, you may request an Independent Medical Review (IMR). For information about the IMR process, please refer to Insert Plan Name's Grievance and Appeals Process on page XX.

Reconstructive Surgery
Cost to Member
No copayment

Description
Medically necessary reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors or disease and are performed to improve function or create a normal appearance to the extent possible. This benefit includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

Phenylketonuria (PKU)
Cost to Member
No-Copayment

Description
Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Clinical Cancer Trials
Cost to member
No copayment

Description
Coverage for a member's participation in a cancer clinical trial, phase I through IV, when the member's physician has recommended participation in the trial, and member meets the following requirements:

- Member must be diagnosed with cancer

- Member must be accepted into a phase I, phase II, Phase III, or phase IV clinical trial for cancer
- Member's treating physician, who is providing covered services, must recommend participation in the clinical trial after determining that participation will have a meaningful potential to the member, and
- The trial must meet the following requirements:
  1. Trials must have a therapeutic intent with documentation provided by the treating physician, and
  2. Treatment provided must be approved by one of the following: 1) the National Institute of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans Administration, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

Benefits include the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical trial program. Routine patient costs for cancer clinical trials include:

- Health care services required for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications

<u>Exclusions</u>

- Provision of non-FDA-approved drugs or devices that are the subject of the trial
- Services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur due to participation in the trial
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient
- Health care services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental)
- Health care services that are customarily provided by the research sponsors free of charge for any enrollee in the trial
- Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California

Annual or Lifetime Benefit Maximums

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

Coordination of Services

California Children's Services (CCS)

As part of the services provided through the Healthy Families Program, members needing specialized medical care may be eligible for services through the California Children's Services (CCS) program.

CCS is a California medical program that treats children with certain physically handicapping conditions and who need specialized medical care. This program is available to all children in California whose families meet certain medical, financial and residential eligibility requirements. All children enrolled in the Healthy Families Program are deemed to have met the financial eligibility requirements of the CCS Program. Services provided through the CCS Program are coordinated by the county CCS office.

If a member's primary care provider suspects or identifies a possible CCS eligible condition, he or she must refer the member to the local CCS program. Insert Plan Name can assist with this referral. Insert Plan Name will also make a referral to CCS when a primary care provider refers the member to a specialist or where there is an inpatient admission which appears to involve care for a CCS eligible condition. The CCS program will determine if the member's condition is eligible for CCS services.

If the condition is determined to be eligible for CCS services, the member will remain enrolled in the Healthy Families Program. He or she will be referred and should receive treatment for the CCS eligible condition through the specialized network of CCS providers and/or CCS approved specialty centers. These CCS providers and specialty centers are highly trained to treat CCS eligible conditions. CCS services must be received from CCS paneled providers and payment for CCS eligible services obtained from non-CCS paneled provider will be the responsibility of the member's legal guardian.

Insert Plan Name will continue to provide primary care, prevention services, and any other services that are not related to the CCS eligible condition, as described in this booklet. Insert Plan Name will also work with the CCS program and providers to coordinate care provided by both the CCS program and Insert Plan Name. If a condition is determined not to be eligible for CCS program services, the member will continue to receive all medically necessary services from Insert Plan Name.

Although all children enrolled in the Healthy Families Program are determined to be financially eligible for the CCS program, the CCS office must verify residential status for each child in the CCS program. If a member is referred to the CCS program, the member's legal guardian will be asked to complete a short application to verify residential status and ensure coordination of the member's care after the referral has been made.

Additional information about the CCS program can be obtained by calling Insert Plan Name's Member Services at Insert Number or by calling the local county CCS program at Insert Number.

County Mental Health Benefits for Serious Emotional Disturbance Children (SED)
If the member exhibits the behaviors listed below, the member may be able to access mental health services through Insert Plan Name.

- Serious problem eating or sleeping
- Often crying or sad
- Saying things that worry you
- Behaving in ways that cause serious family and school problems
- Ongoing or frequent problems with playmates and friends
- Purposefully hurting him/herself and others

As part of the services provided through the Healthy Families Program, members needing specialized mental health services for a Serious Emotional Disturbance (SED) condition will be referred for a SED assessment to their local county mental health department. The referral may be made by the member's primary care provider or by Insert Plan Name. Parents may also refer their child directly to the county mental health department if the parents suspect their child suffers from any of the conditions listed below. The county mental health clinician will have the final determination of whether the child meets SED criteria.

What is Serious Emotional Disturbance (SED)?

SED refers to any diagnosable mental disorder (in a child under age 19) that severely disrupts social, academic, and emotional functioning. A child is considered to have SED if his or her inappropriate behavior does not result from drug or alcohol substance abuse or a developmental disorder.

To determine if a child has a SED condition, he or she must meet one or more of the following criteria:

1. Has substantial difficulties in at least two of the following areas: self-care, school functioning, family relationships, or the ability to function in the community, and either of the following occurs:
   (i) the child is at risk of removal from the home or has already been removed; or
   (ii) the mental health condition has been present for more than 6 months or is likely to continue for more than 1 year if not treated.
2. Shows signs of psychotic behavior, risk of suicide or risk of violence which are related to mental disorder.
3. Meets special education eligibility requirements not related to developmental disorders.

If a member is determined to have a SED condition, care for the SED condition will be provided by the county mental health department. The member will remain enrolled in

the Health Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from Insert Plan Name.

If a member does **not** meet the SED criteria, the member will continue to receive all medically necessary health care services from Insert Plan Name.

When a member is determined to have a SED condition and the member's legal guardian refuses services from the county mental health department and seeks treatment from other providers (even from Insert Plan Name providers), the legal guardian will be responsible for payment for the services.

Services provided by the county for the SED condition are provided to members at no cost and may include:

- Outpatient visits for treatment of SED
- Inpatient mental health care after the member has exhausted 30 inpatient days covered through Insert Plan Name
- Day treatment programs
- Individual or family therapy
- All medications prescribed to treat the SED condition
- Counseling assistance with medication management related to the SED condition

Additional information about services for children with a SED condition can be obtained by contacting the county's mental health department. The phone number of your county mental health department can be found in the government listing section of the phone book under the heading "County Government".

Excluded Benefits

The following health benefits are excluded under the Health Plan:

1. Any services or items specifically excluded in the Benefits Description section.
2. Any benefits in excess of limits specified in the Benefits Description section.
3. Services, supplies, items, procedures, or equipment which are not medically necessary, unless otherwise specified in the Benefits Description section.
4. And services which were received prior to the member's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the member's effective date.
5. Any services which are received subsequent to the time coverage ends.
6. Those medical, surgical (including implants), or other health care procedures services, products, drugs, or devices which are either:
   - Experimental or investigational, or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or
   - Outmoded or not effective.
7. Emergency facility services used for non-emergency conditions.
8. Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under the "Cataract Spectacles and Lenses" benefit.
9. The diagnoses and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.
10. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except when Insert Plan Name determines they are a less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to "Skilled Nursing Care" and "Hospice" benefits.
11. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any worker's compensation benefit plan. Insert Plan Name shall provide services at the time of need, and the member or member's legal guardian shall cooperate to assure that Insert Plan Name is reimbursed for such benefits.
12. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. Insert Plan Name shall provide services at the time of need, and the member or member's legal guardian will cooperate to assure that Insert Plan Name is reimbursed for such benefits.
13. Cosmetic surgery that is solely performed to alter or reshape normal structure of the body in order to improve appearance.

Grievance and Appeals Process

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by plan providers to the courtesy extended you by our telephone representatives.

If you have questions about the services you receive from a plan provider, we recommend that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call Insert Plan Name's Member Service at Insert Number (TDD/TTY for the hearing impaired at Insert Number).

Grievance

You may file a grievance with Insert Plan Name at any time. You can obtain a copy of Insert Plan Name's Grievance Policy and Procedure by calling our Member Service number in the above paragraph. To begin the grievance process, you can call, write, or fax the plan at:

Plan Name
Address
Telephone Number
Fax Number
Website

Insert Plan Name will acknowledge receipt of your grievance within five (5) days and will resolve your grievance within thirty (30) days. If your grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; you or your provider may request that Insert Plan Name expedite its grievance review. Insert Plan Name will evaluate your request for an expedited review and, if your grievance qualifies as an urgent grievance, we will resolve your grievance within three (3) days from receipt of your request.

You are not required to file a grievance with Insert Plan Name before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a grievance with Insert Plan Name in which you ask for an expedited review, Insert Plan Name will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your grievance involving an imminent and serious threat to health, and
2. We will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the grievance no later than 72 hours from receipt of your request to expedite review of your grievance.

Independent Medical Reviews

If medical care that is requested for you is denied, delayed or modified by Insert Plan Name or a plan provider, you may be eligible for an Independent Medical Review (IMR).

If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, Insert Plan Name will provide coverage for the health care services.

An IMR is available in the following situations:

1. (a) Your provider has recommended a health care service as medically necessary, or
   (b) You have received urgent care or emergency services that a provider determined was medically necessary, or
   (c) You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
2. The disputed health care service has been denied, modified, or delayed by Insert Plan Name or one of its plan providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with Insert Plan Name and the disputed decision was upheld or the grievance remains unresolved after 30 calendar days.

If your grievance qualifies for expedited review, you are not required to file a grievance with Insert Plan Name prior to requesting an IMR. Also, the DMHC may waive the requirement that you follow Insert Plan Name's grievance process in extraordinary and compelling cases.

For cases that are not urgent, the IMR organization designated by DMHC will provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function; the IMR organization will provide its determination within three (3) business days. At the request of the experts, the deadline can be extended by up to three (3) days if there is a delay in obtaining all necessary documents.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the care that was requested. You pay no application or processing fees for an IMR. You have the right to provide information in support of your request for IMR. For more information regarding the IMR process or to request an application form, please call Insert Plan Name's Member Services at Insert Number (TDD/TTY for the hearing impaired at Insert Number).

Independent Medical Review for Denials of Experimental/ Investigational Therapies

You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- You are not required to participate in Insert Plan Name's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/ investigational therapy.
- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Insert Plan Name, you should first telephone Insert Plan Name at Insert Number (TDD/TTY for the hearing impaired at Insert Number) and use Insert Plan Name's grievance process before contacting the department. Using this grievance procedure does not prohibit any legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Insert Plan Name, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, 1 (888) HMO-2219, to receive complaints regarding health plans. The hearing and speech impaired may use the department's TDD line (1-877-688-9891) number, to contact the department. The Department's Internet website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

Insert Plan Name's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Arbitration

[Plan to provide language. Please describe the Plan's arbitration process.]

General Information

Other Health Insurance

It is to your advantage to let your network provider know if you have medical coverage in addition to this program. Most carriers cooperate with one another to avoid duplicate payments, but still allow you to make use of both programs.

Coverage provided under this program is secondary to all other coverage, except Medi-Cal. Benefits paid under this program are determined after benefits have been paid as a result of a member's enrollment in any other health care program.

Be sure to advise your provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact Insert Plan Name's Member Service department.

Third Party Recovery Process and Member Responsibilities

The member agrees that, if benefits of this Agreement are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the member is made whole for all other damages resulting from the wrongful act or omission before Insert Plan Name is entitled to reimbursement, member shall:

- Reimburse Insert Plan Name for the reasonable cost of services paid by Insert Plan Name to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Insert Plan Name's effectuation of its lien rights for the reasonable value of services provided by the Insert Plan Name to the extent permitted under California Civil Code section 3040. Insert Plan Name's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

Insert Plan Name shall be entitled to payment, reimbursement, and subrogation in third party recoveries and member shall cooperate to fully and completely effectuate and protect the rights of Insert Plan Name including prompt notification of a case involving possible recovery from a third party.

Non-Duplication of Benefits with Workers' Compensation

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of medical services provided by Insert Plan Name, we will provide the benefits of this Agreement at the time of need. The member will agree to provide Insert Plan Name with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Insert Plan Name. The lien may be filed with the responsible third party, his or her agent, or the court.

For purposes of this subsection, reasonable value will be determined to be the usual, customary, or reasonable charge for services in the geographic area where the services are rendered.

By accepting coverage under this Agreement, members agree to cooperate in protecting the interest of Insert Plan Name under this provision and to execute and to deliver to Insert Plan Name or its nominee any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of Insert Plan Name or its nominee.

Coordination of Benefits

By enrolling in Insert Plan Name each member agrees to complete and submit to Insert Plan Name such consents, releases, assignments and any other document reasonably requested by Insert Plan Name in order to assure and obtain reimbursement and to coordinate coverage with other health benefit plans or insurance policies. The payable benefits will be reduced when benefits are available to a member under such other plan or policy whether or not claim is made for the same.

The fact that a member has double coverage under Insert Plan Name will in no way reduce member's obligation to make all required copayments.

Limitations of Other Coverage

This health plan coverage is not designed to duplicate any benefits to which members are entitled under government programs, including CHAMPUS/TRICARE, Medi-Cal or Workers' Compensation. By executing an enrollment application, a member agrees to complete and submit to Insert Plan Name such consents, releases, assignments, and other documents reasonably requested by Insert Plan Name or order to obtain or assure CHAMPUS/TRICARE or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

Provider Payment

[Plan to provide language. Please describe how the Plan provides payment to the plan's providers including the scope and general methods of payment made to the contracting providers, whether financial bonuses or any other incentives are used, and how the member may request additional information regarding payment to providers.]

Reimbursement Provisions – If You Receive a Bill

[Plan to provide language. Please describe what a member should do if he or she receives a bill or has paid for a covered service and seeks reimbursement.]

Public Participation

[Plan to provide language. Please describe the plan's procedures to permit members to participate in establishing the plan's public policy.]

Notifying You of Changes in the Plan

Throughout the year we may send you updates about changes in the plan. This can include updates for the Provider Directory, Handbook, and Evidence of Coverage. We

will keep you informed and are available to answer any questions you may have. Call us at Insert Number if you have any questions about changes in the plan.

Privacy Practices

[Plan to provide language. Please describe the plan's privacy practices including how the plan maintains the confidentiality of member's medical information and include a statement indicating that a copy of the plan's privacy policies and procedures will be furnished to the member upon request.]

Organ and Tissue Donation

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet website (http://www.organdonor.gov) has additional information on donating your organs and tissues.

Map of the Plan's Service Area

Healthy Families Program Health Plan Fact Sheet

2005-06 Contract Period

If you have any questions regarding this form, please contact Dinorah Torza at (916) 323-2072.

Plan Name:_____

Plan contact person for follow up information: _____
(Name and phone number)

1. What types of physician specialties are offered as pediatric primary care practitioners and adolescent primary care practitioners for prospective Healthy Families Program members in your plan? (This may include nurse practitioners.)

2. Please complete the Pediatric and Adolescent Primary Care Practitioners (PCP) chart below.

Pediatric / Adolescent Primary Care Practitioners	**2002**	**2003**	**2004**
Total number of PCPs in the provider network as of January 1st.	# _____	# _____	# _____
Number of PCPs added to the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Number of PCPs that left the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Total number of PCPs in the provider network as of December 31st.	# _____	# _____	# _____

3. Please complete the pediatric and adolescent specialists chart below.

Pediatric / Adolescent Primary Care Specialists	**2002**	**2003**	**2004**
Total number of specialists in the provider network as of January 1st.	# _____	# _____	# _____
Number of specialists added to the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Number of specialists that left the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Total number of specialists in the provider network as of December 31st.	# _____	# _____	# _____

4. Please complete the Health Plan Primary Care Physician (PCP) Network Capacity Chart below. This chart requires plans to list the percentage of providers accepting new patients and the estimated number of members that the PCPs can serve by county as of January 1, 2005

Health Plan Primary Care Physician (PCP) Network Capacity Chart **Health Plan Name:**_____				
COUNTY	**Number of Pediatric & Adolescent PCPs**	**Number of Pediatric & Adolescent PCPs accepting new patients**	**Percentage of Pediatric & Adolescent PCPs accepting new patients**	**Estimated number of pediatric & adolescent patients that can be served in each county**
Alameda				
Alpine				
Amador				
Butte				
Calaveras				
Colusa				
Contra Costa				
Del Norte				
El Dorado				
Fresno				
Glenn				
Humboldt				
Imperial				
Inyo				
Kern				
Kings				
Lake				
Lassen				
Los Angeles				
Madera				
Marin				
Mariposa				
Mendocino				
Merced				
Modoc				
Mono				
Monterey				
Napa				
Nevada				
Orange				
Placer				
Plumas				
Riverside				
Sacramento				
San Benito				
San Bernardino				
San Diego				
San Francisco				
San Joaquin				
San Luis Obispo				
San Mateo				
Santa Barbara				
Santa Clara				
Santa Cruz				
Shasta				
Sierra				
Siskiyou				
Solano				
Sonoma				
Stanislaus				
Sutter				
Tehama				
Trinity				
Tulare				
Tuolumne				
Ventura				
Yolo				
Yuba				

5. What percentage of your health plan's physicians are board-certified?

6. What was the physician and hospital compensation in your health plan in 2004 for the Healthy Families Program (for current participating plans only)?

Compensation	PCP Providers	Specialist Providers	Compensation	Hospitals
Capitation	%	%	Capitation	%
Fee Schedule	%	%	Fee Schedule	%
Salary	%	%	Per Diem	%
Combination of the above (explain)			Combination of the above (explain)	

7. Please respond to the following questions and describe the procedures used for delivering health care services.

I. Primary Care Provider Assignment
a) Describe how the plan will meet the contractual requirement to use a fair and equitable method of automatic assignment, which will include the geographic accessibility and language capability of pediatric/adolescent providers in your network, if a member does not select a primary care provider. (See Exhibit A, Item II.G.)
b) How often can members change their PCP in one benefit year? Describe the process.
II. Members Access to Services
a) Describe how the plan will implement the contractual requirement to provide information to new members regarding how to access services. (See Exhibit A, Item II.F.1.a. for examples of acceptable approaches.)
b) Can HFP female members see an OB/GYN without a referral from a PCP?
c) Describe the process for accessing a specialist in the plan. Please address whether specialists are affiliated with specific PCPs or can be accessed by any member or PCP.
d) Describe how members can access a provider for urgent care services outside normal ambulatory setting operating hours. (This can include a 24 hour advice line.)

e) Describe how members can access a provider for emergency care services outside normal ambulatory setting operating hours.

f) Please describe how the plan will comply with the contract requirement that the plan's providers are made aware of the importance of screening for overweight and obese children. (See Exhibit A, Item V.C.3.)

g) Please describe how the plan will comply with the contract requirement to increase applicants' and members' awareness of the health risks associated with being overweight or obese and the importance of good nutrition and physical activity. (See Exhibit A, Item V.C.3.)

III. Mental Health and Substance Abuse Services

a) How will the plan assess the mental health needs of members?

b) How will the plan assess the needs of members in regards to alcohol use, drug abuse, and tobacco use?

c) Please describe the process for providing alcohol, drug abuse and tobacco prevention services.

d) Specify what, if any, arrangements are made for the provision of services once the maximum alcohol and drug benefit limit is reached.

e) Will the plan contract with a mental health "carve-out" company or will the plan have mental health providers either on staff or on contract? If a "carve-out" behavioral health company is used, what level of supervision and accountability is maintained to make sure that appropriate services are delivered?

f) Will the plan use the substitution of inpatient mental health days for day treatment, outpatient visits, or residential treatment days to provide more than the 20 outpatient visits as authorized in Article 3. of the Program Regulations? If yes, explain the substitution method that is used.

g) To what extent are mental health providers authorized or encouraged to incorporate family members and primary caregivers in the treatment of children with mental health needs?

IV. Pharmacy Services

a) Please describe the process members use to obtain prescription drugs. Will the plan require the use of a prescription drug card?

b) Will the plan offer a prescription drug mail-order program? If so, briefly describe the program. Include the ability of members to receive maintenance prescription drugs through the mail.

c) Will the plan have a mandatory formulary? Please describe the appeal process for accessing drugs not included on the formulary.

d) Will the plan use a mandatory generic drug substitution policy? Please describe the process for accessing brand name drugs when a generic substitution is available.

V. Member Cost Sharing

a) Describe the arrangement the plan has with providers to provide for extended payment plans for members utilizing a significant number of health services for which copayments are required.

b) How will the plan implement the federal government's requirement to exempt American Indian and Alaska Native children in HFP from all copayments in the program?

VI. Member Complaints and Grievances

a) Describe the plan's policies and procedures for the submittal, processing and resolution of members' complaints and grievances. Please include the plan's mechanism for documenting, tracking and ensuring that members' complaints and grievances are acknowledged and responded to within the required timeframes.

b) How will the plan contact members/applicants regarding complaints? (For example, through the use of staff dedicated to members on complaints and grievances.) Include the process for how non-English speaking members are assisted.

VII. Member Service

a) How will the plan monitor and evaluate call waiting time and the busy or abandonment rates on the customer service phone lines?

b) Describe how the plan will determine if there is sufficient bilingual staff available on the customer service telephone lines to serve members in all the threshold languages.

c) Describe the system that will be used to ensure compliance with the contractual requirement to provide an Identification Card, Provider Directory and Evidence of Coverage booklet to applicants, on behalf of members, no later than the members' effective date of coverage. For currently participating plans: Please attach to the completed fact sheet a copy of a sample internal report used by your plan to track your performance in this area. (See Exhibit A, Item II.F.)

8. Describe any agreements contemplated or in progress between the plan and other parties which may effect the plan's ownership, corporate structure or management during the January 2005 through June 2006 time period (as allowed by State and Federal Law).

9. Describe any restrictions or pending reviews by state (including the Medi-Cal program) or federal authorities for non-compliance with state or federal regulations or contracts for medical services.

This 2005 Health Plan Fact Sheet for the Healthy Families Program must be signed by the person authorized to sign the health plan's contract.

To the best of my knowledge, all statements and data reported by _____ (health plan) in this Health Plan Fact Sheet 2005/2006 for the Healthy Families Program are true and accurate. I understand that all responses to questions included in the Fact Sheet, except items # 8 and # 9, may be included in comparative charts in the Healthy Families Program brochure or other public documents produced by MRMIB.

Signed

_____
Name

_____
Title

_____
Date

Instructions for Health Plans with a 2004-05 HFP Contract
Plan Descriptions, Comparative Charts and the Language Grid

PLAN DESCRIPTIONS

Attached is your plan description from the 2004-05 HFP Handbook. Please update the description, if necessary, by indicating changes in red ink. Any changes to your current plan description should be consistent with the following:

1. **Plan Description Length and Typeface**
   Plan descriptions must be limited to no more than 310 words. Descriptions that are too long will be revised. The font and font size can be no smaller than Times 10 point.

   Plans will have the opportunity to review the revised information and layout in the HFP Handbook before the final production. Please note that new changes will not be accepted during this review.

2. **Plan logo, toll-free numbers, and language capabilities**
   a. Plan logo should appear in the designated 1" x 2 ¾" space on the page.
   b. Plan's toll-free phone number should appear under the logo. All toll-free numbers for each service area or different services should be included if applicable.
   c. Phone hours.
   d. Language capabilities.

LOGO
1-800-111-2222
Call 7am to 7pm
English and Spanish

3. **Text to be included**
   a. Why choose your plan:
      Plan may include comments regarding quality assurance and/or accreditations received.
   b. How the plan works:
      Plans should provide a clear and concise description for this section. This should be the longest section.
   c. How to choose:
      This section should be brief.

COMPARATIVE CHARTS AND LANGUAGE GRID

Attached are the comparative chart and the language grid from the 2004-05 HFP Handbook. Please update your plan's information by indicating changes in red ink.

Plan Description, Comparative Chart and Language Grid Changes Verification Sheet

Plan Description

_____ We do not have changes for the current plan description.

____ We have made the enclosed changes to the current plan description.

Comparative Chart

____ We do not have changes for the current comparative chart.

____ We have made the enclosed changes to the current comparative chart.

Language Grid

_____ We do not have changes for the language grid

_____ We have made the enclosed changes to the Language grid

Plan Contact Information	
Name:	_____
E-mail address:	_____
Telephone Number:	_____
Fax Number:	_____
Date of submission:	_____

[Plan-specific Plan Description, Comparative Chart and Language Grid will be provided to currently participating plans in October 2004]

Instructions for Health Plans Not Currently Participating in HFP
Plan Descriptions, Comparative Charts and the Language Grid

PLAN DESCRIPTIONS

Please complete the attached Plan Description. The Plan Description should be consistent with the following:

1. **Plan Description Length and Typeface**
   Plan descriptions must be limited to no more than 310 words. Descriptions that are too long will be revised. The font and font size can be no smaller than Times 10 point.

   Plans will have the opportunity to review the revised information and layout in the HFP Handbook before the final production. Please note that new changes will not be accepted during this review.

2. **Plan logo, toll-free numbers, and language capabilities**
   a. Plan logo should appear in the designated 1" x 2 ¾" space on the page.
   b. Plan's toll-free phone number should appear under the logo. All toll-free numbers for each service area or different services should be included if applicable.
   c. Phone hours.
   d. Language capabilities.

LOGO
1-800-111-2222
Call 7am to 7pm
English and Spanish

3. **Text to be included**
   a. Why choose your plan:
      Plan may include comments regarding quality assurance and/or accreditations received.
   b. How your plan works:
      Plans should provide a clear and concise description for this section. This should be the longest section.
   c. How to choose:
      This section should be brief.

COMPARATIVE CHARTS AND LANGUAGE GRID

Attached are copies of the comparative chart and the language grid from the 2004-05 HFP Handbook. Please complete the attached Comparative Chart and Language Grid.

Program Description

PLAN LOGO

Toll Free Telephone Number
Customer Service Hours
Language Capabilities

Why choose Insert Plan Name

How The Plan Works

How to Choose

Comparative Chart

Answers To Commonly Asked Questions About Health Plans

Are all members required to have a primary care physician (PCP)?	
Should a member get a referral from a PCP before going to a specialist?	
How many times can members change their PCP in one benefit year?	
Does the plan offer a prescription drug mail-in program?	
Does the plan ask members to substitute generic for brand name drugs, except when medically necessary?	
Does the plan provide the following optional benefits:	
Biofeedback	
Acupuncture	
Chiropractic	
More than 20 outpatient alcohol and drug visits per benefit year	
Elective abortions	
Health Plan Statistics:	
Total number of CA members**	
What types of specialists are offered as PCPs in this plan?	
General Practice	
Family Practice	
Pediatrician	
OB/GYN	
Internal Medicine	
Other:	
Quality Accreditations (NCQA/JCAHO)?	
Type of Accreditation	
Does the plan require its members to use Binding Arbitration to resolve disputes?***	

** This number represents the insurance plan's membership as of January 1, 2005.
*** To get additional information about each insurance plan's dispute resolution provision, call the plan or refer to the plan's Disclosure Form and Evidence of Coverage booklet, which is available upon request from each health plan.

Language Grid

The following chart shows which plans have made written materials available in different languages.

Plan Name	Evidence of Coverage	Member Handbook and Welcome Letters	Newsletters and Brochures	Medical Care Reminders
Plan 1	Spanish, Chinese	Spanish, Chinese	Spanish, Chinese, Vietnamese	Spanish, Chinese, Vietnamese
Plan 2	Spanish, Korean, Chinese	Spanish, Korean, Chinese	Spanish, Korean, Chinese	Spanish, Korean, Chinese
Your Plan				

Healthy Families Program Health Plan Payment for Vaccinations

2005-06 Contract Period

If you have any questions regarding this form, please contact Dinorah Torza at (916) 323-2072.

Plan Name:_____

Plan contact person for follow up information: _____
(Name and phone number)

For each region in which the plan participates, please complete the following:

1. Describe how providers are paid for the cost of vaccinations.

   A. Fee-for-service payment

Retail price for vaccines	
Discounted price for vaccines	
Payment per vaccine:	
Diptheria, Tetanus, Purtussis	
Td Booster	
Oral Polio	
intravenous polio	
Measles, Mumps, Burbeel	
Heamapholus B	
Hepatitis B	
Varicella	
Hepatitis A	
Influenza	
Payment for vaccine administration	

B. Payment for vaccine included in capitation payment. (Capitation rates are adjusted by age to recognize vaccine costs.)

Average cap rate paid for all children	
Dollar amount included in the cap rate for vaccines for the following age groups:	
< 31 days old	
31 – 365 days old	
1-5 years old	
6-10 years old	
11-15 old	
16-18 old	

2. Do providers receive any incentive payments based on vaccination completion rates? If yes, please describe.

3. If providers are subcapitated, please provide information on how vaccine costs are covered.

Plan Name

HEALTHY FAMILIES PROGRAM
Cultural and Linguistic Services Report

This report is to be completed by plans with a 2004-05 HFP contract (**"current plans"**) and all plans proposing to serve HFP subscribers in 2005-08 (**"proposed plans"**). **Proposed plans** include plans new to HFP (**"new plans"**), as well as current plans proposing to continue serving HFP subscribers.

Plans should report in a narrative format the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited English proficient applicants and subscribers in the Program. Submission of this report fulfills the requirement in the 2004-05 contract for currently participating plans to submit a C&L report by December 10, 2004 (Exhibit A, Item III.C.3.c.). Please follow the instructions carefully and note that proposed plans must provide additional information.

NOTE: Responses to all or part of the following questions may be made publicly available.

A. Linguistic Services

Current plans and proposed plans should complete this section with reference to ***current*** *C&L services for HFP subscribers. New plans should complete the responses with reference to a current non-HFP product line and identify the product line used. Additionally, all proposed plans should indicate what changes, if any, they would make to their current C&L services to fulfill the model contract requirements for 2005-06.*

1. a. ***(for current and proposed plans)*** Please describe the plan's current methodology for assigning members to culturally and linguistically appropriate providers.

   b. ***(for proposed plans)*** Would the plan make any changes for 2005-06?

2. ***(for current and proposed plans)*** Please describe how the plan currently makes interpreter services available to subscribers. **Proposed plans** should additionally describe any changes the plan would make for 2005-06 to comply with the HFP model contract. In your description, please:

   a. Describe how the plan provides 24 hour access to interpreter services for all limited English proficient (LEP) subscribers, including the accommodations for providing an interpreter, if requested, for a scheduled appointment. Describe how the plan ensures that subcontracted providers comply with these requirements. (Reference: HFP Contract, Exhibit A, Item III.C.1.b.)

   b. Describe how the plan identifies LEP subscribers, records the language needs of each LEP subscriber in the subcriber's membership record, and informs each LEP subscriber's designated provider of the subscriber's language needs. (Reference: HFP Contract, Exhibit A, Item III.C.1.c.)

c. Describe how the plan ensures and monitors that requests or refusals of language interpreter services by subscribers are documented in the medical records of plan providers. (Reference: HFP Contract, Exhibit A, Item III.C.1.d.)

d. Provide a copy of the policies and procedures discussed in Items 2.a., 2.b., and 2.c.

e. Describe how the plan ensures that subscribers and providers are made aware of the availability of free interpreter services through the plan. (Reference: HFP Contract, Exhibit A, Item III.C.1.e)

   In your description, please:

   i. Describe how the plan informs subscribers and providers of:

      a) The availability of interpreter services at no charge;
      b) The subscriber's right not to use family members or friends as interpreters;
      c) The subscriber's right to request an interpreter during discussions of medical information, such as diagnosis of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers;
      d) The subscriber's right to receive written materials in the subscriber's primary language;
      e) The subscriber's right to file a complaint or grievance if he or she believes his or her linguistic needs are not met.

   ii. Provide a copy of the policies and procedures discussed in 2.e. and 2.e.i.

f. Describe how the plan ensures that there is appropriate bilingual proficiency at medical and non-medical points of contact. (Reference: HFP Contract, Exhibit A, Item III.C.1.f.)

B. Translation of Written Materials

Current plans should complete the following responses with reference to current translations for HFP subscribers. New plans should respond with reference to a current non-HFP product line and identify the product line used.

1. ***(for current and proposed plans)*** For each of the member materials listed below, please list the non-English languages in which the plan translates the materials. Please note that the information provided will be included in comparative charts in the Healthy Families Program brochure or other public documents. (Reference: HFP Contract, Exhibit A, Item III.C.2.a).

Plan Documents	***Current Languages***
Evidence of Coverage document (or Certificate of Insurance)	
Member Handbook and information on how to use "member handbook"	
Welcome letter	
Newsletters	
Preventive services reminders	
Disclosure forms	
Consent Forms	
Letter and notices reducing, denying, modifying or terminating services or benefits	
Form letters	
Letters and notices requiring a response from the subscriber	
Patient satisfaction surveys	
Notice of free language assistance	
Provider listings	
Marketing materials	
Complaints and Grievance process materials	
Emergency Room follow-up	
Any documents required by law or affecting any legal right or responsibility	
Other (please describe)	

2. a. ***(for current and proposed plans)*** Describe how the plan currently ensures that members who are unable to read the written materials that have been translated into non-English languages have access to the contents of the written materials. (Reference: HFP Contract Exhibit A, Item III.C.2.a.)

   b. ***(for proposed plans)*** Describe any changes that would be made for 2005-06 to provide an alternative form of access for subscribers described in 2.a. and to provide written materials at a sixth grade reading level. (Reference: HFP Model Contract Exhibit A, Item II.C.2.a.)

3. a. ***(for current and proposed plans)*** Describe how the plan ensures the quality of currently translated materials. (Reference: HFP Contract Exhibit A, Item III.C.2.b.)

   b. ***(for proposed plans)*** Describe any changes that would be made for 2005-06 to ensure the quality of translated materials. (Reference: HFP Model Contract Exhibit A, Item III.C.2.b.)

C. Cultural and Linguistic Group Needs Assessment (to be completed by current plans only)

1. In your last C & L report, your plan included an update of activities and services to implement findings from your Group Needs Assessment (GNA). Please provide an update in your response. (Reference: HFP Contract, Exhibit A, Item III.C.3.a)

   a. What services and/or activities did your plan accomplish in the **2003-04** Benefit year?

   b. What services and/or activities in the outline provided in your last C&L report for **2003-04** have not been accomplished? Please describe your current plans of action and timeline for implementation of the activities.

   c. What additional or new services or activities will your plan be implementing in **2004-05** to further address the GNA findings? Please include an outline of these services and/or activities and the timeline for implementation with milestones.

2. Describe how your plan provides an opportunity for representatives of subscribers enrolled in the Program to provide input in the development of health education programs in response to needs identified in your plan's GNA. If a committee was used, please provide name of the committee and how often the committee meets. (Reference: HFP Contract, Exhibit A, Item III.C.3.c)

D. Operationalizing Cultural and Linguistic Competency

Current plans should complete this section with reference to C&L policies and procedures for HFP subscribers. New plans should complete the responses with reference to a current non-HFP product line and identify the product line used.

1. a. ***(for current plans only)*** Describe the internal systems the plan developed during the **2003-04** year to meet the cultural and linguistic needs of subscribers. In your response, please indicate whether any of the following were implemented: (Reference: HFP Contract, Exhibit A, Items III.C.3.a and III.C.3.b.)

    i. Establishing and maintaining a process to evaluate and determine the need for special initiatives related to cultural competency
    ii. Developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community
    iii. Establishing a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines
    iv. Providing an array of communication tools to distribute information to staff relating to cultural competency issues
    v. Maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data
    vi. Evaluating the effectiveness of strategies and programs in improving the health status of cultural defined populations

    b. ***(for current and proposed plans)*** Describe any activities that the plan has or will implement in **2004-05** to develop its internal systems.

    c. ***(for proposed plans)*** Describe any activities that the plan will implement in **2005-06** to develop its internal systems. (Reference: HFP Model Contract Exhibit A, Items III.4.a. and III.4.b.)

2. a. ***(for current and proposed plans)*** Describe what initial and continuing training on cultural competency is given to staff and providers (include course description, date, duration, and frequency of training session). (Reference: HFP Model Contract, Exhibit A, Item III.C.4.a)

    i. How is the effectiveness of this training evaluated? Include feedback from subscriber surveys, staff, providers, encounter/ claim data.

    ii. Provide a copy of training curriculum presented to staff and providers.

    b. ***(for proposed plans)*** Describe any changes the plan would make for 2005-06 to comply with the model contract. (Reference: HFP Model Contract, Exhibit A, Item III.C.4.a.)

3. a. ***(for current and proposed plans)*** Describe how the plan participates with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure the plan maintains current information and an outside perspective in its policies. (Reference: HFP Model Contract, Exhibit A, Item III.C.4.b.)

   b. **(for proposed plans)** Describe any changes the plan would make for 2005-06.

4. a. ***(for current and proposed plans)*** Describe how the plan assesses the cultural competence of the plan's providers on a regular basis. (Reference: HFP Model Contract, Exhibit A, Item III.C.4.b.)

   b. ***(for proposed plans)*** Describe any changes the plan would make for 2005-06.

5. a. ***(for current and proposed plans)*** Describe how the plan ensures that referrals to culturally and linguistically appropriate community services program are made. (Reference: HFP Model Contract, Exhibit A, Item III.C.4.c.)

   b. ***(for proposed plans)*** Describe any changes the plan would make for 2005-06.

6. a. ***(for current and proposed plans)*** Describe how the plan evaluates its cultural and linguistic services and outcomes of cultural and linguistic activities as part of the plan's ongoing quality improvement effort. (Reference: HFP Model Contract, Exhibit A, Item III.C.4.c)

   b. ***(for proposed plans)*** Describe any changes the plan would make for 2005-06.

Contact Person	**e-mail**
Title	**Phone Number**

CCC-304

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	*Federal ID Number*
By (Authorized Signature)	
Printed Name and Title of Person Signing	
Date Executed	*Executed in the County of*

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (GC 12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

   a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

   b. Establish a Drug-Free Awareness Program to inform employees about:
      1) the dangers of drug abuse in the workplace;
      2) the person's or organization's policy of maintaining a drug-free workplace;
      3) any available counseling, rehabilitation and employee assistance programs; and,
      4) penalties that may be imposed upon employees for drug abuse violations.

   c. Every employee who works on the proposed Agreement will:
      1) receive a copy of the company's drug-free workplace policy statement; and,
      2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

   Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be

ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (GC 8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (PCC 10296) (Not applicable to public entities.)

4. UNION ORGANIZING: Contractor hereby certifies that no request for reimbursement, or payment under this agreement, will seek reimbursement for costs incurred to assist, promote or deter union organizing.

5. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

   Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

   Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

6. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

7. SWEATFREE CODE OF CONDUCT:

   a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in

sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

8. DOMESTIC PARTNERS: Commencing on July 1, 2004 Contractor certifies that it is in compliance with Public Contract Code section 10295.3 with regard to benefits for domestic partners. For any contracts executed or amended, bid packages advertised or made available, or sealed bids received on or after July 1 2004 and prior to January 1, 2007, a contractor may require an employee to pay the costs of providing additional benefits that are offered to comply with PCC 10295.3.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

   a. Current State Employees (PCC 10410):

      1) No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

      2) No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

   b. Former State Employees (PCC 10411):

      1) For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2) For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (PCC 10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (PCC 10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

   a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

   b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

   c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing

body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

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STATE OF CALIFORNIA

ENCLOSURE 7

STANDARD AGREEMENT

STD 213 (Rev 06/03)

HFP STATE SUPPORTED SERVICES	AGREEMENT NUMBER **05MHF0XXX**
MODEL CONTRACT 2005-2008	REGISTRATION NUMBER

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME

Managed Risk Medical Insurance Board, **hereinafter "the State"**

CONTRACTOR'S NAME

2. The term of this Agreement is: July 1, 2005 through June 30, 2008

3. The estimated amount of this Agreement is: **$**

4. The parties agree to comply with the terms and conditions of the following exhibits which are by this reference made a part of the Agreement.

Exhibit A – Scope of Work	page(s)
Exhibit B – Budget Detail and Payment Provisions	page(s)
Attachment I-Confidential Rates of Payment	page(s)

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR	***California Department of General Services Use Only***
CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*	
BY *(Authorized Signature)* ✍ / DATE SIGNED *(Do not type)*	
PRINTED NAME AND TITLE OF PERSON SIGNING	
ADDRESS	
STATE OF CALIFORNIA	
AGENCY NAME: Managed Risk Medical Insurance Board	
BY *(Authorized Signature)* ✍ / DATE SIGNED *(Do not type)*	
PRINTED NAME AND TITLE OF PERSON SIGNING: Dennis Gilliam, Contracts Administrator	☐ Exempt per:
ADDRESS: 1000 G. Street, Suite 450, Sacramento, CA 95814	

EXHIBIT A
SCOPE OF WORK

I. TERM OF AGREEMENT

The term of this Agreement shall be from July 1, 2005 through June 30, 2008.

II. INCORPORATION OF PROVISIONS

All terms of Agreement Number 05MHF0XX between the State and Contractor, including all amendments as of the effective date of this Agreement and all Exhibits and Attachments to that Agreement, are hereby incorporated by reference as if fully set forth herein, except as provided in Section III of this Exhibit and the following items in Agreement Number 05MHF0XX:

a. Exhibit B, Item I.A, Fees Provided to the Contractor
b. Exhibit B, Item I.B, Payment Schedule
c. Exhibit B, Item I.C, Special Enrollment Materials Cost
d. Exhibit B, Item II.C, Availability of Federal Funds
e. Exhibit B, Item II.D., Prior to Fiscal Year/Crossing Fiscal Years
f. Exhibit B, Item II.E., Healthy Families Fund Encumbrance
g. Exhibit B, Item II.I, Contractor Performance Standards, Liquidated Damages and Remedy for Non-Performance, item g., California Children's Services Report and item h., Mental Health: Services for Subscribers with Serious Emotional Disturbance Report
h. Attachment VI, Confidential Rates of Payment

III. BENEFITS

The covered benefits under this agreement are limited to State Supported Services as defined in the program regulations. Contractor shall provide State Supported Services to program subscribers. No other health care services are covered under this Agreement.

EXHIBIT B
BUDGET DETAILS AND PAYMENT PROVISIONS

I. PAYMENT PROVISIONS

A. Fees Provided to Contractor for State Supported Services

1. The State shall pay the Contractor a flat fee per month per subscriber child of the age of one or over for State Supported Services. This fee is set forth in Attachment I, Confidential Rates of Payment.

2. In cases of subscriber eligibility and enrollment appeals which result in liability of health care costs by the State for State Supported Services, the Contractor shall pay the provider for State Supported Services delivered within 30 days following notification by the State of the appeal finding and shall claim reimbursement by the State within 45 days after notification by the State of the appeal findings. The State shall pay the Contractor the actual costs paid by the Contractor for services received by the subscriber. The Contractor shall reimburse and claim for such services at any discounted rate that the Contractor may have in place for the provider in the program and that is accepted by the provider as payment in full. Such payments may only be made by the Contractor and paid by the State when the Contractor receives prior written direction from the State.

B. Payment Schedule

1. For the first month or partial month of a subscriber's coverage the State agrees to pay one hundred percent (100%) of the fee described in Item I.A.1. of this Exhibit for subscribers with effective dates of coverage on the first (1st) through fifteenth (15th) day of the month. No fee shall be paid for the first partial month of coverage for subscribers whose coverage begins on the sixteenth (16th) through thirty-first (31st) day of the month. The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.

2. For all months of coverage after the first month in which a subscriber's coverage becomes effective, the State agrees to pay the fee described in Item I.A.1. of this Exhibit . The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.

II. FISCAL CONTROL PROVISIONS

A. Availability of Federal Funds

1. It is mutually understood between the parties that this Agreement may have been written for the mutual benefit of both parties, before ascertaining the availability of Congressional appropriation of funds applicable to Agreement Number 05MHFOXX between the State and Contractor, to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

2. Even though no federal funds shall used to pay for State Supported services purchased under this Agreement. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purposes of Agreement Number 05MHF0XX. between the State and Contractor for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or to any statute enacted by the Congress that may affect the provisions, terms or funding of Agreement Number 05MHFOXX between the State and Contractor in any manner.

3. The parties mutually agree that if Congress does not appropriate sufficient funds for Agreement Number 05MHF0XX. between the State and Contractor, this Agreement shall be amended to reflect any reduction in funds.

4. The State has the option to invalidate this Agreement under the 30 day termination clause in Exhibit D, Item I.B. of Agreement 05MHF0XX between the State and the Contractor or to amend the Agreement to reflect any reduction in funds.

B. Prior to Fiscal Year/Crossing Fiscal Years

It is mutually agreed between the parties that this Agreement may have been signed and executed prior to the start of the 2005-06 State Fiscal Year, before ascertaining the availability of funds for the 2005-06 State Fiscal Year. This Agreement has also been written with a term that crosses State Fiscal Years, and therefore before ascertaining the availability of legislative appropriation of funds for the 2006-07 and 2007-08 State Fiscal Years. This Agreement is valid and enforceable only if sufficient funds are made available through the 2006-07 and 2007-08 State Budgets for the purposes of this Program. In addition, this Agreement is subject to any additional restrictions, limitations, or

conditions enacted in statute by the State Legislature which may affect the provision, term or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature does not appropriate sufficient funds for this Program, the Agreement shall be amended to reflect any reduction in funds and enrollment shall be curtailed by the State proportionately.

C. Healthy Families Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the Healthy Families Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Items I. A. and I. B of this Exhibit.

ATTACHMENT I
CONFIDENTIAL RATES OF PAYMENT

In accordance with Government Code Section 6254, this attachment is confidential, and is not open until, at the earliest, July 1, 2009.

ONE YEAR PREMIUM RATES FOR STATE SUPPORTED SERVICES

Subscriber Child Premium Rates for the July 1, 2005 - June 30, 2006 benefit year.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber Child ages 1 thru 18						

TWO YEAR PREMIUM RATES FOR STATE SUPPORTED SERVICES

Subscriber Child Premium Rates for the July 1, 2005 - June 30, 2007 benefit years.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber Child ages 1 thru 18						

Plan Name: _____

Contact Person: _____

Telephone: _____

e-mail : _____

California Healthy Families

Rating Sheets for Contract Year July 2005 through June 2006

Instructions

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Schedule 1: If applicable, provide historical utilization and costs for your Healthy Families Program (HFP) population by region, and for the state as a whole if your product is in more than one region. Provisions for incurred but not reported (IBNR) claims should be included in the reported figures, as appropriate. For each category of service, please provide the

1) Please provide the Healthy Families member months for the data period. This information is used in the calculated fields to derive the "Annual Utilization rate per 1,000 members" [**Column D**] and the "Gross Cost Per Unit of Service" **[Column E].**

2) **Column A:** a description of what the unit counts represent (for example, inpatient days, claims, units of service).

3) **Column B**: the total costs by service category

4) **Column C**: the total unit counts by service category

5) **Column D** - **Calculated Field:** The annual utilization rate per 1,000 members. This is calculated as units of service provided during the data period divided by the member months for the data period multiplied by 12,000.

6) **Column E** - **Calculated Field:** The gross cost per unit of service. This is calculated as total costs of service **[Column B]** divided by the total units of service **[Column C]** provided during the data period.

7) **Column F**: the average copay per unit of service. This should be calculated as the total copayments collected divided by the total units of service, within each category.

8) **Column G** - **Calculated Field:** the Net Cost Per Unit. This is calculated as the "Gross Cost per Unit" **[Column E]** minus the "Copay per Unit" entered in **Column F**.

9) **Column H** - **Calculated Field:** Cost PMPM. This is calculated by multiplying the "annual utilization rate per 1,000 members" **[Column D]** and the "net cost per unit" **[Column G]** and dividing the result by 12,000.

California Healthy Families
Rating Sheets for Contract Year July 2005 through June 2006

Instructions

Schedule 2: Using experience from the HFP provide projected trends and other adjustments for your HFP population by region. For 2004-2005, plans new to the HFP within the past 2 years should skip to Schedule 3B.

1) Enter your expected annual utilization and unit cost trend rates from the data period through the 2005-2006 contract period. For example, if you project Inpatient Hospital Med/Surg utilization will decrease by 5% per year and unit costs will increase by 10% per year, enter -5 and 10 in the Utilization and Unit Cost columns, respectively. The annual trend rate for per member per month costs is automatically calculated. The trend factors (the amount by which your reported experience will be adjusted for trend are also automatically calculated). If the appropriate number of trend months is different than 24, please enter the correct number and provide an explanation for the difference. The number of trend months should be from the midpoint of the experience period to the midpoint of the contract period (1/1/2005). Also, please provide an explanation of the source of your trend assumptions in the space provided.
2) As appropriate, enter any additional adjustment factors to be applied to project historical costs to the contract period. These factors will be automatically applied to the historical utilization rates to produce the projected utilization in Schedule 3A. Provide a brief description of the reason for the adjustments next to the factor. Further space is provided at the bottom of the schedule if necessary to adequately describe the nature of the adjustments.

Schedule 3A: This schedule develops the expected 2005-2006 health care costs for the HFP population in each region. Schedule 3A is automatically populated using the reported experience and the assumptions in Schedule 2.

Schedule 3B: Complete this schedule only if your plan was new to HFP within the past two years. You may use data other than HFP experience for the rate development process. Identify the data source for the utilization and cost assumptions. As in Schedule 1, enter the utilization, unit cost, and copayment assumptions in **columns (A), (B), (C), (F)**. **Columns (D), (E), (G), (H)** are calculated fields. The unadjusted health care cost will be automatically calculated. Make the adjustments in Schedule 3C.

California Healthy Families
Rating Sheets for Contract Year July 2005 through June 2006

Instructions

Schedule 3C: If Schedule 3B was completed, calculate the following adjustments and enter in Schedule 3C. The adjusted health care cost will be automatically calculated.

A. Identify the adjustment made to reflect the nominal number of newborns likely to be covered by the program. Medi-Cal covers most newborns in families with incomes up to 200% of FPL. Infants above 200% are covered in a separate HFP rate for health plans which MRMIB will calculate based on data in house.

B. Identify the adjustment made to reflect the nominal level of maternity services that are likely to be required.

C. Identify the adjustment made to reflect that health plans are not responsible for covering the costs of California Children's Services conditions.

D. Identify the adjustment made to reflect that community mental health departments provide mental health services to children defined as having a serious emotional disturbance.

Schedule 4: Report administrative costs per member per month for the HFP in the categories shown. Enter your projected health care costs from Schedule 3A or Schedule 3C, as appropriate. Schedule 4 calculates the projected rate as the sum of the administrative costs and the projected health care costs.

Schedules 5 and 6: Complete the loss ratio report. For current HFP plans, the expenses reported on Line 17 (TOTAL MEDICAL AND HOSPITAL) of Schedule 7 should be equivalent to the Total Health Care Expenditures calculated at the bottom of Schedule 1.

For health plans submitting information for multiple regions, the Schedules 6 and 7 submitted should be a consolidation for all regions. Also, this Schedule 6 and 7 should be in the workbook for the first region that your plan is submitting a projection for (ie. If your plan is submitting for Regions 1 through 6, then the consolidated Schedule 6 and 7, will be in the workbook for Region 1).

Schedule 7: Fill out this schedule if your loss ratio is below your contractual level. The schedule asks for an explanation if the loss ratio is below the contractual level and for a description of the methods you intend to use to reach your target loss ratio.

California Healthy Families
Rating Sheets for Contract Year July 2005 through June 2006

Instructions

Schedules 8A and 8B: This is a presentation of your rate projection and must equal the Schedule 4 Line 25 & 26.

Schedule 9:
Part A **-** Report your plan's members by payor at the end of December 31, 2004.
Part B - Report the compensation paid each provider type by basis of payment. (For example: capitation, per diem, salary.)

Schedule 10: Answer the questions regarding your healthplan's incentive payment and pay for performance programs.

Schedule 11: Provide a certification by your health plan's actuary that the experience for 2003-2004 is accurate and that the assumptions used to project costs during the contract period are reasonable.

Submit Schedules 1 through 11 via e-mail to Stuart Busby, Financial Operations Officer (sbusby@mrmib.ca.gov). Mail a signed copy of Schedule 11 (Actuarial Certification) to Stuart Busby c/o MRMIB, 1000 G St. Suite 450, Sacramento, CA 95814. All documents must be received by 5 p.m. January 6, 2005.

Schedule 1

California Healthy Families
July 2005 - June 2006 Rate Development
Utilization and Cost Experience July 2003 through June 2004
Fill out one for each Region and Statewide (if applicable)

Plan Name _____ (Specify Region or Statewide) _____

HFP Member Months July 2003 - June 2004 [ ]

Health care services	(A) Description of Units (e.g., days, claims, units of service)	(B) Total Cost	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
Inpatient Hospital								
Med/Surg					$ -		$ -	$ -
Maternity					$ -		$ -	$ -
Newborn					$ -		$ -	$ -
Mental Health					$ -		$ -	$ -
Chemical Dependency					$ -		$ -	$ -
Abortion - Federally sponsored (1)					$ -		$ -	$ -
Abortion - State sponsored (2)					$ -		$ -	$ -
Rehab Care & SNF					$ -		$ -	$ -
Capitation								$ -
Provider Incentive Payments								$ -
Total								$ -
Outpatient Hospital & Surgical Center								
Emergency Room					$ -		$ -	$ -
Clinic					$ -		$ -	$ -
Mental Health					$ -		$ -	$ -
Chemical Dependency					$ -		$ -	$ -
Abortion - Federally sponsored (1)					$ -		$ -	$ -
Abortion - State sponsored (2)					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Professional								
Well baby/child					$ -		$ -	$ -
Immunizations/injections					$ -		$ -	$ -
Physician office visits					$ -		$ -	$ -
Surgery					$ -		$ -	$ -
Mental Health					$ -		$ -	$ -
Chemical Dependency					$ -		$ -	$ -
Abortion - Federally sponsored (1)					$ -		$ -	$ -
Abortion - State sponsored (2)					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Chiropractic/Acupuncture					$ -		$ -	$ -

Schedule 1

California Healthy Families
July 2005 - June 2006 Rate Development
Utilization and Cost Experience July 2003 through June 2004
Fill out one for each Region and Statewide (if applicable)

Plan Name _____ (Specify Region or Statewide) _____

HFP Member Months July 2003 - June 2004 [ ]

Health care services	(A) Description of Units (e.g., days, claims, units of service)	(B) Total Cost	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
Ancillary Services								
Home Health (Including Hospice)					$ -		$ -	$ -
Diagnostic x-ray/lab					$ -		$ -	$ -
DME & Supplies					$ -		$ -	$ -
Physical & Occupational Therapy					$ -		$ -	$ -
Speech Therapy					$ -		$ -	$ -
Prescription drugs					$ -		$ -	$ -
Other					$ -		$ -	$ -
Capitation								$ -
Net Reinsurance Costs								$ -
UM/QA Costs								$ -
Total								$ -
Provider Incentive Payments								$ -
Grand total excluding Provider Incentive Payments								$ -
Grand total including Provider Incentive Payments								$ -

Total Health Care Expenditures $0

(1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

Schedule 2

California Healthy Families
July 2005 - June 2006 Rate Development
Assumptions used to project costs for July 2005 - June 2006
Fill out one for each Region

Plan Name

Specify Region

Months of Trend (should be 24 if data from 2003/2004 contract year used as the base): 24

If different than 24, please explain:

Health care services	Annualized Trend Rates			Trend Factors			Other Adjustments	
	Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Factors	Description
Inpatient Hospital								
Med/Surg			0.00%	1.000	1.000	1.000	1.000	
Maternity			0.00%	1.000	1.000	1.000	1.000	
Newborn			0.00%	1.000	1.000	1.000	1.000	
Mental Health			0.00%	1.000	1.000	1.000	1.000	
Chemical Dependency			0.00%	1.000	1.000	1.000	1.000	
Abortion - Federally Sponsored (1)			0.00%	1.000	1.000	1.000	1.000	
Abortion - State Sponsored (2)			0.00%	1.000	1.000	1.000	1.000	
Rehab Care & SNF			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								
Outpatient Hospital & Surgical Center								
Emergency Room			0.00%	1.000	1.000	1.000	1.000	
Clinic			0.00%	1.000	1.000	1.000	1.000	
Mental Health			0.00%	1.000	1.000	1.000	1.000	
Chemical Dependency			0.00%	1.000	1.000	1.000	1.000	
Abortion - Federally Sponsored (1)			0.00%	1.000	1.000	1.000	1.000	
Abortion - State Sponsored(2)			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								
Professional								
Well baby/child			0.00%	1.000	1.000	1.000	1.000	
Immunizations/injections			0.00%	1.000	1.000	1.000	1.000	
Physician office visits			0.00%	1.000	1.000	1.000	1.000	
Surgery			0.00%	1.000	1.000	1.000	1.000	
Mental Health			0.00%	1.000	1.000	1.000	1.000	
Chemical Dependency			0.00%	1.000	1.000	1.000	1.000	
Abortion - Federally Sponsored (1)			0.00%	1.000	1.000	1.000	1.000	
Abortion - State Sponsored (2)			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								
Chiropractic/Acupuncture			0.00%	1.000	1.000	1.000	1.000	

Schedule 2

California Healthy Families
July 2005 - June 2006 Rate Development
Assumptions used to project costs for July 2005 - June 2006
Fill out one for each Region

Plan Name

Specify Region

Months of Trend (should be 24 if data from 2003/2004 contract year used as the base): 24

If different than 24, please explain:

Health care services	Annualized Trend Rates			Trend Factors			Other Adjustments	
	Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Factors	Description
Ancillary Services								
Home Health (Including Hospice)			0.00%	1.000	1.000	1.000	1.000	
Diagnostic x-ray/lab			0.00%	1.000	1.000	1.000	1.000	
DME & Supplies			0.00%	1.000	1.000	1.000	1.000	
Physical & Occupational Therapy			0.00%	1.000	1.000	1.000	1.000	
Speech Therapy			0.00%	1.000	1.000	1.000	1.000	
Prescription drugs			0.00%	1.000	1.000	1.000	1.000	
Other			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Net Reinsurance Costs						1.000	1.000	
UM/QA Costs						1.000	1.000	
Total								

Grand total

(1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

Source of trend assumptions:

Other Adjustments:

Schedule 3A

California Healthy Families
July 2005 - June 2006 Rate Development
Projected Health Care Costs for July 2005 - June 2006
Based on Healthy Families Experience Projection
Fill out one for each Region

Plan Name _____ Specify Region _____

Health care services	(A) Annual Units per 1000 Members	(B) Gross Cost per Unit	(C) Copay per Unit	(D) Net Cost per Unit	(E) Cost PMPM
Inpatient Hospital					
Med/Surg		$ -	$ -	$ -	$ -
Maternity		$ -	$ -	$ -	$ -
Newborn		$ -	$ -	$ -	$ -
Mental Health		$ -	$ -	$ -	$ -
Chemical Dependency		$ -	$ -	$ -	$ -
Abortion - Federally Sponsored (1)		$ -	$ -	$ -	$ -
Abortion - State Sponsored (2)		$ -	$ -	$ -	$ -
Rehab Care & SNF		$ -	$ -	$ -	$ -
Capitation					$ -
Provider Incentive Payments					$ -
Total					$ -
Outpatient Hospital & Surgical Center					
Emergency Room		$ -	$ -	$ -	$ -
Clinic		$ -	$ -	$ -	$ -
Mental Health		$ -	$ -	$ -	$ -
Chemical Dependency		$ -	$ -	$ -	$ -
Abortion - Federally Sponsored (1)		$ -	$ -	$ -	$ -
Abortion - State Sponsored (2)		$ -	$ -	$ -	$ -
Capitation					$ -
Provider Incentive Payments					$ -
Total					$ -
Professional					
Well baby/child		$ -	$ -	$ -	$ -
Immunizations/injections		$ -	$ -	$ -	$ -
Physician office visits		$ -	$ -	$ -	$ -
Surgery		$ -	$ -	$ -	$ -
Mental Health		$ -	$ -	$ -	$ -
Chemical Dependency		$ -	$ -	$ -	$ -
Abortion - Federally Sponsored (1)		$ -	$ -	$ -	$ -
Abortion - State Sponsored (2)		$ -	$ -	$ -	$ -
Capitation					$ -
Provider Incentive Payments					$ -
Total					$ -
Chiropractic/Acupuncture		$ -	$ -	$ -	$ -

Schedule 3A

California Healthy Families
July 2005 - June 2006 Rate Development
Projected Health Care Costs for July 2005 - June 2006
Based on Healthy Families Experience Projection
Fill out one for each Region

Plan Name

Specify Region

Health care services	(A) Annual Units per 1000 Members	(B) Gross Cost per Unit	(C) Copay per Unit	(D) Net Cost per Unit	(E) Cost PMPM
Ancillary Services					
Home Health (Including Hospice)		$ -	$ -	$ -	$ -
Diagnostic x-ray/lab		$ -	$ -	$ -	$ -
DME & Supplies		$ -	$ -	$ -	$ -
Physical & Occupational Therapy		$ -	$ -	$ -	$ -
Speech Therapy		$ -	$ -	$ -	$ -
Prescription drugs		$ -	$ -	$ -	$ -
Other		$ -	$ -	$ -	$ -
Capitation					$ -
Net Reinsurance Costs					$ -
UM/QA Costs					$ -
Total					$ -
Grand total including Provider Incentive Payments					$ -
Provider Incentive Payments					$ -
Grand total excluding Provider Incentive Payments					$ -

(1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

Schedule 3B

California Healthy Families
July 2005 - June 2006 Rate Development
Projected costs for July 2005 - June 2006
New Plans (in Healthy Families 2 years or less)
Fill out one for each Region

Plan Name

Specify Region

Data source for developing assumptions [e.g., Commercial, Other (describe)]:

Member Months July 2003 - June 2004

Health care services	(A) Description of Units (e.g., days, claims, units of service)	(B) Total Costs	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
Inpatient Hospital								
Med/Surg					$ -		$ -	$ -
Maternity					$ -		$ -	$ -
Newborn					$ -		$ -	$ -
Mental Health					$ -		$ -	$ -
Chemical Dependency					$ -		$ -	$ -
Abortion - Federally Sponsored (1)					$ -		$ -	$ -
Abortion - State Sponsored (2)					$ -		$ -	$ -
Rehab Care & SNF					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Outpatient Hospital & Surgical Center								
Emergency Room					$ -		$ -	$ -
Clinic					$ -		$ -	$ -
Mental Health					$ -		$ -	$ -
Chemical Dependency					$ -		$ -	$ -
Abortion - Federally Sponsored (1)					$ -		$ -	$ -
Abortion - State Sponsored (2)					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Professional								
Well baby/child					$ -		$ -	$ -
Immunizations/injections					$ -		$ -	$ -
Physician office visits					$ -		$ -	$ -
Surgery					$ -		$ -	$ -
Mental Health					$ -		$ -	$ -
Chemical Dependency					$ -		$ -	$ -
Abortion - Federally Sponsored (1)					$ -		$ -	$ -
Abortion - State Sponsored (2)					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Chiropractic/Acupuncture					$ -		$ -	$ -

Schedule 3B

California Healthy Families
July 2005 - June 2006 Rate Development
Projected costs for July 2005 - June 2006
New Plans (in Healthy Families 2 years or less)
Fill out one for each Region

Plan Name

Specify Region

Data source for developing assumptions [e.g., Commercial, Other (describe)]:

Member Months July 2003 - June 2004

Health care services	(A) Description of Units (e.g., days, claims, units of service)	(B) Total Costs	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
Ancillary Services								
Home Health (Including Hospice)					$ -		$ -	$ -
Diagnostic x-ray/lab					$ -		$ -	$ -
DME & Supplies					$ -		$ -	$ -
Physical & Occupational Therapy					$ -		$ -	$ -
Speech Therapy					$ -		$ -	$ -
Prescription drugs					$ -		$ -	$ -
Other					$ -		$ -	$ -
Capitation								
Net Reinsurance Costs								
UM/QA Costs								
Total								$ -
Grand total								$ -

(1) Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.
(2) State sponsored abortion is all other than Federally sponsored.

GO ON TO SCHEDULE 3C

Schedule 3C

California Healthy Families
July 2005 - June 2006 Rate Development
Projected costs for July 2005 - June 2006
New Plans (in Healthy Families 2 years or less)

Plan Name

(Specify Region or Statewide)

Health care services

Adjustments:	Cost PMPM
Reduction for 0 - 1 year olds *	$ -
Reduction for maternity *	$ -
Reduction for California Children's Services	$ -
Reduction for Community Mental Health Services	$ -
Total health care costs after adjustments	$ -

* Maternity and newborn services will generally be provided by this program only when the mother is a program participant prior to becoming pregnant or infants from 200% to 250% fpl for which there is a separate health rate.

Schedule 4

California Healthy Families
July 2005 - June 2006 Rate Development
Projected costs for July 2005 - June 2006
Administrative Costs and Rate Projection

Plan Name

Specify Region

Administrative costs	Cost PMPM	Percent of premium
Claims processing, data processing, customer service		0.00%
General administrative overhead	$ -	0.00%
Marketing: Communication, education, printing	$ -	0.00%
Provider contracting, managed care network maintenance	$ -	0.00%
Risk charges (identify) _____	$ -	0.00%
Profit	$ -	0.00%
Other (identify) _____	$ -	0.00%
Total administrative costs	$ -	0.00%
Total health care costs from Schedule 3A or 3C	$ -	0.00%
Total health care costs plus administrative costs (total per member per month premium)	$ -	0.00%
Rate projection excluding State sponsored Abortions	$ -	0.00%
Rate projection for State Sponsored Abortions	$ -	0.00%

Schedule 5

HEALTHY FAMILIES PROGRAM
July 2005 - June 2006 Rate Development
7/03 - 6/04 LOSS RATIO REPORT

Plan Name _____

Did your plan have a minimum 1,000 HFP enrolled subscribers per month for six of more months in the July 03 - June 04 benefit year?

Yes	
No	

NOTE: All Plans, regardless of enrollment must complete the loss ratio report.

Total $ amount of covered benefits for services provided to HFP subscribers from 7/1/03 - 6/30/04*	$ -
Total $ amount of premiums received from the state for HFP subscribers from 7/1/03 - 6/30/04 **	$ -
Total $ amount received as incentive payment from 7/1/03 - 6/30/04	$ -
Healthy Families Program 7/1/03 - 6/30/04 Benefit Year Actual Loss Ratio excluding Incentive Payments ***(Sch. 6: Item 17/ Item 1)***	0.00%
Healthy Families Program 7/1/03 - 6/30/04 Benefit Year Actual Loss Ratio including Incentive Payments ***(Sch. 6: Item 4 plus 17/ item 1***	0.00%
Healthy Families Program 7/1/03 - 6/30/04 Benefit Year Minimum Loss Ratio in Contract	
Difference between Actual Loss Ratio without Incentive Payment above and Minimum Loss Ratio in Contract	0.00%
Difference between Actual Loss Ratio with Incentive Payment above and Minimum Loss Ratio in Contract	0.00%

* Total from Item # *17* on the Statement of Revenue and Expenses Report, Schedule 6

** Total from Item # *1* on the Statement of Revenue and Expenses Report, Schedule 6

If your plan's **Actual Loss Ratio** is lower than the **Minimum Loss Ratio in Contract**, complete the Loss Ratio Description Schedule 7

Schedule 6

HEALTHY FAMILIES PROGRAM 2003-2004 LOSS RATIO REPORT
STATEMENT OF REVENUE AND EXPENSES

Plan Name _____ **Healthy Families Benefit Year July 1, 2003 - June 30, 2004**

SUBSCRIBER MONTHS (Healthy Families Program subscribers only)

1. Premium Payments from State	$ -

AFFILIATED ENTRIIES AND NONAFFILIATED ENTRIES:

2. Incentive Payments to affiliated parties	$ -
3. Incentive Payments by to nonaffiliated parties.	$ -
4. Total Incentive Payments	**$ -**

EXPENSES: (Healthy Families Program only)

Medical and Hospital:

5. Inpatient Services - Capitated	$ -
6. Inpatient Services - Per Diem	$ -
7. Inpatient Services - Fee-for-service/Case Rate	$ -
8. Primary Professional Services - Capitated	$ -
9. Primary Professional Services - Non-Capitated	$ -
10. Other Medical Professional Services - Capitated	$ -
11. Other Medical Professional Services - Non-Capitated	$ -
11. Non-Contracted Emergency Room and Out-of-Area Expense, not including POS	
13. POS Out-of-Network Expense	$ -
14. Pharmacy Expense	$ -
15. Other Medical Expense	$ -
16. Aggregate Write-ins for Other Medical and Hospital Expense	$ -
17. TOTAL MEDICAL AND HOSPITAL (***Line 5*** to ***Line 16***)	**$ -**

Administration:

18. Compensation	$ -
19. Interest Expense	$ -
20. Occupancy, Depreciation and Amortization	$ -
21. Management Fees	$ -
22. Marketing	$ -
23. Affiliate Administration Services	$ -
24. Aggregate Write-ins for Other Administration Expenses	$ -
25. TOTAL ADMINISTRATION (***Line 18*** to ***Line 24***)	**$ -**
26. TOTAL EXPENSES (***Lines 4, 17,and 25***)	**$ -**
27. INCOME/(LOSS) ***(Line 1*** less ***Line 26)***	**$ -**
28. Extraordinary Item	$ -
29. Provision for Taxes	$ -
30. NET INCOME/(LOSS) ***(Line 27*** plus ***Lines 28 & 29)***	**$ -**

Line 17 TOTAL MEDICAL AND HOSPITAL EXPENSE	**$ -**
Schedule 1 Total Health Care Expenditures	**$ -**
Difference	**$ -**

Explain any differences _____

Schedule 7

HEALTHY FAMILIES PROGRAM 2003-2004 LOSS RATIO REPORT

Plan Name _____

If your plan's Actual Loss Ratio is lower than your Minimum Loss Ratio in Contract, provide a detailed response explaining 1) why the acutal loss ratio was significantly below the contractual standard and 2) plans you have to assure the Board that future loss ratios will be consistent with the contractual standard agreed to in your contract. Please respond to the following specific questions. Your response can be provided in a separate file if you prefer.

1. Why is your company's actual loss ratio substantially lower than the projected value for the 2003-2004 benefit year?

2. How do your HFP provider payments to each segment of the provider community (primary care physicians, clinics, medical groups, specialty physicians, and hospitals) compare to your contractual payments in:
   - The MediCal Program?
   - Commercial products?
   - The payment schedules set forth in the Medicare program?

3. How does your company's HFP utilization experience in each of the major service categories (physician services, pharmaceuticals, inpatient care) compare to your company's children's utilization experience in:
   - The MediCal Program?
   - Commercial products?

4. Does your plan offer providers any type of "end of year" payment incentive program? If so, please describe. Include in your description any differences in the allocation of incentive payments to affiliated and non-affiliated groups or other distinctions in how incentive payments are made by group.

5. What does your plan do to encourage families to seek out and utilize preventive services such as immunizations and well child visits? Do you have plans to improve provider's behavior with regard to providing and reporting appropriate preventive care visits? If so, please describe.

6. Are there other factors that explain your plan's low loss ratio? If yes, please describe.

7. What are the methods you will use to reach your target loss ratio?
   When would you expect that to occur?

Healthy Families Program
Contract No. _____

*PREMIUM RATES - INCLUDING FEDERALLY SPONSORED ABORTIONS**

Note: Projection should match the figure shown in Schedule 4.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

* Federally sponsored abortion is necessary due to rape, incest and to save the life of the mother.

Healthy Families Program
Contract No. _____

*PREMIUM RATES - STATE SPONSORED ABORTIONS**

Note: Projection should match the figure shown in Schedule 4.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

* State sponsored abortion is all other than Federally sponsored.

Schedule 9

HEALTHY FAMILIES PROGRAM
July 2005 - June 2006 Rate Development
Program and Provider Type Detail for Dec 31, 2003 to Dec 31, 2004

Plan Name: _____

Part A

	31-Dec-03		31-Dec-04	
	Total Employees	Total Members	Total Employees	Total Members
Individual Market				
Small Group Market (2-50)				
Large Group Market (51+)				
Medi-Cal				
Medicare				
Other (Please Specify)				
All California Business				

Part B

The physician and hospital compensation during 2003-2004 for the Healthy Families Program

	PCP Providers	Specialist Providers	Hospitals	
Capitation	0.00%	0.00%	0.00%	Capitation
Fee Schedule	0.00%	0.00%	0.00%	Fee Schedule
Salary	0.00%	0.00%	0.00%	Per Diem
Combination	0.00%	0.00%	0.00%	Combination
Total per provider type	**0.00%**	**0.00%**	**0.00%**	

Schedule 10

HEALTHY FAMILIES PROGRAM
July 2005 - June 2006 Rate Development
Provider Incentive and Pay for Performance Programs

Plan Name: _____

Please provide your answers to the following questions on a separate sheet.

General

1. Does your healthplan use incentive payments or pay for performance components in contracts with providers for any of your lines of business, including Healthy Families?
2. If the answer to Question 1 is no, do you have plans to add these components in the future? If yes, please describe the expected structure of the program and anticipated implementation date.

If your answers to Questions 1 and 2 are "No", you are finished with this Schedule

3. How long has your healthplan used incentive payments or pay for performance programs in its contracts with providers? If different systems have been in place for different periods of time, please indicate the length of time for each system.
4. Please describe the incentive or pay for performance programs you have in place, including the criteria used to determine payment amounts. If you use more than one sytem, please describe each and indicate which is the predominant system. Also, please indicate the system in place for your Healthy Families business. If the measurement criteria is different for your Healthy Families business versus your non-Healthy Families business, please describe how it differs.
5. Please describe the types and percentages of providers eligible for these payments and the actual percentage of each provider type receiving such payments.
6. Depending on how your program is structured, please describe the percentage of total compensation or percentage increase in base compensation can be earned as a result of incentive payments or payments for performance.

Healthy Families Expenditure Data for July 2003 - June 2004

7. Did your plan include amounts related to provider incentive payments or pay for performance in the cost information shown in Schedule 1?

   If the answer to this question is "No", proceed to next section.

8. Do the amounts summarized in Row 65 of Schedule 1 include all costs related to incentive payments or pay for performance? If no, please provide the additional amounts and describe how they differ from the amounts reported in Row 65.
9. Please describe the criteria upon which the determination of all incentive payments and payments for performance were made. Please be specific.

Healthy Families Proposed Rates for July 2005 - June 2006

10. Do the rates you proposed for the July 2005 - June 2006 benefit period include incentive or pay for performance components?

If your answers to this question is "No", you are finished with this Schedule

11. Please provide the percentage of your proposed July 2005 - June 2006 Healthy Families premium associated with expected incentive payments or payment for performance.
12. Please describe how you estimated the incentive payment or pay for performance amounts included in these premium rates.
13. Describe the criteria upon which the determination of incentive payments or payment for performance is expected to be determined during the July 2005 - June 2006 rate period. Please be specific.

Schedule 11

California Healthy Families
July 2005 - June 2006 Rate Development
Projected costs for July 2005 - June 2006 and Loss Ratio Report Certification

Plan Name _____

I certify that the claims experience and cost projections are accurate and appropriate for the California Healthy Families Program.

By: _____

Print name _____ Date _____

Signature & Title _____ Phone number _____

California Healthy Families
Infant Rate Development - First 60 Days of Life
July 2005 - June 2006 Rate Development

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Instructions

Schedules 1: Provide historical utilization and costs for an infant's **first 60 days of life**. Use data that you believe is credible and reasonably consistent with expected experience under HFP. Schedule 2 provides a means for adjustment to expected HFP utilization and cost levels. Provisions for incurred but not reported (IBNR) claims should be included in the reported figures. Please specify which line of business the experience basis reflects [AIM, Commercial business, or Medi-Cal] as applicable to your plan. In addition, for each category

1) Please provide member months associated with the infants' first 60 days of life for the data period. The remainder of the values are automatically calculated. This information is used in the calculated fields to derive the "Annual Utilization rate per 1,000 members" [**Column D**] and the "Gross Cost Per Unit of Service" **[Column E].**
2) **Column A:** a description of what the unit counts represent (for example, inpatient days, claims, units of service).
3) **Column B**: the total costs by service category
4) **Column C**: the total unit counts by service category
5) **Column D** - **Calculated Field:** The annual utilization rate per 1,000 members. This is calculated as units of service provided during the data period divided by the member months for the data period multiplied by 12,000.
6) **Column E** - **Calculated Field:** The gross cost per unit of service. This is calculated as total costs of service **[Column B]** divided by the total units of service **[Column C]** provided during the data period.
7) **Column F**: the average copay per unit of service. This should be calculated as the total copayments collected divided by the total units of service, within each category.
8) **Column G** - **Calculated Field:** the Net Cost Per Unit. This is calculated as the "Gross Cost per Unit" **[Column E]** minus the "Copay per Unit" entered in **Column F**.
9) **Column H** - **Calculated Field:** Cost PMPM. This is calculated by multiplying the "annual utilization rate per 1,000 members" **[Column D]** and the "net cost per unit"

California Healthy Families
Infant Rate Development - First 60 Days of Life
July 2005 - June 2006 Rate Development

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Instructions

Schedule 2: Provide projected trends and other adjustments to reflect your expected **first 60 days of life** experience under the HFP program.

1) Enter your expected annual utilization and unit cost trend rates from the data period through the 2005-2006 contract period. For example, if you project Inpatient Hospital Med/Surg utilization will decrease by 5% per year and unit costs will increase by 10% per year, enter -5 and 10 in the Utilization and Unit Cost columns, respectively. The annual trend rate for per member per month costs is automatically calculated. The trend factors (the amount by which your reported experience will be adjusted for trend are also automatically calculated). If the appropriate number of trend months is different than 24, please enter the correct number and provide an explanation for the difference. The number of trend months should be from the midpoint of the experience period to the midpoint of the contract period (1/1/2006). Also, please provide an explanation of the source of your trend assumptions in the

2) As appropriate, enter any additional adjustment factors to be applied to reflect expected costs for HFP infant in their **first 60 days of life** during in the contract period. These factors will be automatically applied to the historical utilization rates to produce the projected utilization in Schedule 3A. Provide a brief description of the reason for the adjustments next to the factor. Further space is provided at the bottom of the schedule if necessary to adequately describe the nature of the adjustments.

Schedule 3A: This schedule develops the expected 2005-2006 health care costs for HFP infants in their **first 60 days of life** in each region. Schedule 3A is automatically populated using the reported experience and the assumptions in Schedule 2.

Schedule 3B: Provide the expected per member per month value of California Children's Services coverage for HFP infants in their **first 60 days of life**.

Schedule 4: Provide administrative costs per member per month related to HFP infants in their **first 60 days of life** for the categories shown. Your projected health care costs from Schedule 3B will automatically be carried forward. Schedule 4 calculates the projected rate as the sum of the administrative costs and the projected health care costs. This rate represents your proposed payment rate for HFP infants in their **first 60 days of life**.

California Healthy Families
Infant Rate Development - First 60 Days of Life
July 2005 - June 2006 Rate Development

Prepare a separate projection for each Healthy Families region in which you are submitting a bid. Highlighted cells containing certain key calculations are locked and cannot be modified.

Instructions

Schedule 5: Provide a distribution of payments the **first 60 days of life** for the line of business specified in Schedule 1. The total payments in these schedules should match the total expenditures from Schedule 1, with the exception of non-claim items (e.g., capitation, provider incentives, etc.).

Schedule 6: Provide a certification by your plan's actuary that the experience for 2003-2004 is accurate and that the assumptions used to project costs during the contract period are reasonable.

Submit Schedules 1 through 6 via e-mail to Stuart Busby, Financial Operations Officer (sbusby@mrmib.ca.gov). Mail a signed hard copy of Schedule 6 (Actuarial Certification) to Stuart Busby c/o MRMIB, 1000 G St. Suite 450, Sacramento, CA 95814. All documentation must be received by 5 p.m. January 6, 2005.

Schedule 1

California Healthy Families
July 2005 - June 2006 Infant Rate Development - First 60 Days of Life
Utilization and Cost Experience July 2003 through June 2004
Fill out one for each Region and Statewide (if applicable)

Plan Name | Description of Experience Data | (Specify Region or Statewide)

Member Months for July 2003 - June 2004

Health care services	(A) Description of Units (e.g., days, claims, units of service)	(B) Total Cost	(C) Total Units	(D) Annual Units per 1000 Members	(E) Gross Cost per Unit	(F) Copay per Unit	(G) Net Cost per Unit	(H) Cost PMPM
Inpatient Hospital								
Med/Surg					$ -		$ -	$ -
Newborn					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Outpatient Hospital & Surgical Center								
Emergency Room					$ -		$ -	$ -
Clinic					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Professional								
Well baby/child					$ -		$ -	$ -
Immunizations/injections					$ -		$ -	$ -
Physician office visits					$ -		$ -	$ -
Surgery					$ -		$ -	$ -
Capitation								
Provider Incentive Payments								
Total								$ -
Ancillary Services								
Diagnostic x-ray/lab					$ -		$ -	$ -
DME & Supplies					$ -		$ -	$ -
Prescription drugs					$ -		$ -	$ -
Other					$ -		$ -	$ -
Capitation								
Net Reinsurance Costs								
UM/QA Costs								
Total								$ -
Grand total including Provider Incentive Payments								$ -
Provider Incentive Payments								$ -
Grand total excluding Provider Incentive Payments								$ -
Total Health Care Expenditures								$ -

California Healthy Families

Schedule 2

July 2005 - June 2006 Infant Rate Development - First 60 Days of Life

Assumptions used to project costs to July 2005 - June 2006

Fill out one for each Region

Plan Name _____ Specify Region _____

Months of Trend (should be 24 if data from 2003/2004 contract year used as the base): 24

If different than 24, please explain: _____

Health care services	Annualized Trend Rates			Trend Factors			Other Adjustments	
	Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Factors	Description
Inpatient Hospital								
Med/Surg			0.00%	1.000	1.000	1.000	1.000	
Newborn			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total							1.000	
Outpatient Hospital & Surgical Center								
Emergency Room			0.00%	1.000	1.000	1.000	1.000	
Clinic			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								
Professional								
Well baby/child			0.00%	1.000	1.000	1.000	1.000	
Immunizations/injections			0.00%	1.000	1.000	1.000	1.000	
Physician office visits			0.00%	1.000	1.000	1.000	1.000	
Surgery			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Provider Incentive Payments						1.000	1.000	
Total								
Ancillary Services								
Diagnostic x-ray/lab			0.00%	1.000	1.000	1.000	1.000	
DME & Supplies			0.00%	1.000	1.000	1.000	1.000	
Prescription drugs			0.00%	1.000	1.000	1.000	1.000	
Other			0.00%	1.000	1.000	1.000	1.000	
Capitation						1.000	1.000	
Net Reinsurance Costs						1.000	1.000	
UM/QA Costs						1.000	1.000	
Total								
Grand total								

Source of trend assumptions:

_____

_____

Other Adjustments:

_____

_____

California Healthy Families

Schedule 3A

July 2005 - June 2006 Infant Rate Development - First 60 Days of Life

Projected Health Care Costs for July 2005 - June 2006

Fill out one for each Region

Plan Name

Specify Region

Health care services	(A) Annual Units per 1000 Members	(B) Gross Cost per Unit	(C) Copay per Unit	(D) Net Cost per Unit	(E) Cost PMPM
Inpatient Hospital					
Med/Surg		$ -	$ -	$ -	$ -
Newborn		$ -	$ -	$ -	$ -
Capitation					$ -
Provider Incentive Payments					$ -
Total					$ -
Outpatient Hospital & Surgical Center					
Emergency Room		$ -	$ -	$ -	$ -
Clinic		$ -	$ -	$ -	$ -
Capitation					$ -
Provider Incentive Payments					$ -
Total					$ -
Professional					
Well baby/child		$ -	$ -	$ -	$ -
Immunizations/injections		$ -	$ -	$ -	$ -
Physician office visits		$ -	$ -	$ -	$ -
Surgery		$ -	$ -	$ -	$ -
Capitation					$ -
Provider Incentive Payments					$ -
Total					$ -

California Healthy Families

Schedule 3A

July 2005 - June 2006 Infant Rate Development - First 60 Days of Life

Projected Health Care Costs for July 2005 - June 2006

Fill out one for each Region

Plan Name

Specify Region

Health care services	(A) Annual Units per 1000 Members	(B) Gross Cost per Unit	(C) Copay per Unit	(D) Net Cost per Unit	(E) Cost PMPM
Ancillary Services					
Diagnostic x-ray/lab		$ -	$ -	$ -	$ -
DME & Supplies		$ -	$ -	$ -	$ -
Physical & Occupational Therapy		$ -	$ -	$ -	$ -
Other		$ -	$ -	$ -	$ -
Capitation					$ -
Net Reinsurance Costs					$ -
UM/QA Costs					$ -
Total					$ -
Grand total including Provider Incentive Payments					$ -
Provider Incentive Payments					$ -
Grand total excluding Provider Incentive Payments					$ -

California Healthy Families

Schedule 3B

July 2005 - June 2006 Infant Rate Development - First 60 Days of Life

California Children's Services Adjustment

Plan Name

(Specify Region or Statewide)

Health care services	Cost PMPM
Program Adjustments:	
Reduction for California Children's Services	
Total health care costs after adjustments	$ -

California Healthy Families
July 2005 - June 2006 Infant Rate Development - First 60 Days of Life
Administrative Costs and Rate Projection

Schedule 4

Plan Name

Specify Region

Administrative costs	Cost PMPM	Percent of premium
Claims processing, data processing, customer service		0.00%
General administrative overhead	$ -	0.00%
Marketing: Communication, education, printing	$ -	0.00%
Provider contracting, managed care network maintenance	$ -	0.00%
Risk charges (identify) _____	$ -	0.00%
Profit	$ -	0.00%
Other (identify) _____	$ -	0.00%
Total administrative costs	$ -	0.00%
Total health care costs from Schedule 3B	$ -	0.00%
Total health care costs plus administrative costs (total per member per month premium)	$ -	0.00%

California Healthy Families

Schedule 5

July 2005 - June 2006 Infant Rate Development - First 60 Days of Life

Program Cost Experience for July 2003 through June 2004

Claim Payment Distribution

Plan Name	Line of Business	(Specify Region or Statewide)

Payment Range	Total Payments	Number of Claimants	Average Cost per Claimant	Distribution of Claimants
$0 - $5,000			#DIV/0!	#DIV/0!
$5,001 - $10,000			#DIV/0!	#DIV/0!
$10,001 - $20,000			#DIV/0!	#DIV/0!
$20,001 - $30,000			#DIV/0!	#DIV/0!
$30,001 - $40,000			#DIV/0!	#DIV/0!
$40,001 - $50,000			#DIV/0!	#DIV/0!
$50,001 - $75,000			#DIV/0!	#DIV/0!
$75,001 - $100,000			#DIV/0!	#DIV/0!
$100,001 - $150,000			#DIV/0!	#DIV/0!
$150,001 - $200,000			#DIV/0!	#DIV/0!
$200,001 - $300,000			#DIV/0!	#DIV/0!
$300,001 - $500,000			#DIV/0!	#DIV/0!
$500,001 +			#DIV/0!	#DIV/0!
Total	$ -	-	#DIV/0!	#DIV/0!

California Healthy Families

Schedule 6

July 2005 - June 2006 Infant Rate Development - First 60 Days of Life

Projected costs for July 2005 - June 2006

Certification of Claims Experience and Cost Projections

Plan Name

I certify that the claims experience and cost projections are accurate and appropriate for the California Healthy Families Program.

By:

Print name | Date

Signature & Title | Phone number

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 327-9661

Healthy Families Program
Rural Health Demonstration Projects
2005-2007 Contract Exhibit and Proposal Solicitation

This notice provides important information regarding the Managed Risk Medical Insurance Board's (MRMIB) intention to address unique access problems of rural areas and special populations in the Healthy Families Program (HFP). **Entities eligible to respond to this solicitation are those health, dental, and vision plans that respond to the general solicitation to provide services to HFP subscribers for the period of July 1, 2005 through June 30, 2008.**

The Rural Health Demonstration Project (RHDP) solicitation covers proposals for two fiscal years, July 1, 2005 through June 30, 2006 and July 1, 2006 through June 30, 2007. Funding for these projects will be awarded for the two fiscal years.

A bidder's conference on the general solicitation and the RHDP will be held on Tuesday, November 09, 2004, from 1:00 p.m. to 4:00 p.m., in the auditorium of the State Personnel Board, 801 Capitol Mall, Sacramento, California. During the bidder's conference, MRMIB staff will review the RHDP Contract Exhibit and Solicitation Package and answer questions from participating plans. The RHDP solicitation will be the last agenda item in the bidder's conference.

This packet contains the necessary information to participate in the RHDP for the July 1, 2005 through June 30, 2007 contract period. **Entities wishing to submit a proposal must ensure their proposals are received at the MRMIB offices by no later than 5:00 p.m. Friday, January 14, 2005.** Late submissions will not be accepted.

Background

The HFP is a state and federally funded health, dental and vision coverage program for children with family incomes above the income limit for no-cost Medi-Cal and at or below 250% of the federal poverty level ($3,265/mo. for a family of three). The program began coverage for children on July 1, 1998. The MRMIB administers the HFP.

The Rural Health Demonstration Projects (RHDPs) are authorized in Section 12693.91 of the Insurance Code. Since their inception in FY 1998-99, the RHDPs have increased access to health, dental, and vision care through the implementation of two strategies.

- **Geographic Access Strategy:** The Geographic Access Strategy funds projects that address the lack of adequate health care services in rural and frontier

communities. Plans submitting proposals under the Geographic Access Strategy must propose projects addressing access issues within the boundaries of rural MSSAs. Under this strategy, MRMIB provides incentives to participating HFP plans in the form of rate enhancements or lump sum payments to develop services in isolated rural areas where such services are severely limited or do not exist.

The definition of "rural" as used in the RHDP is an area of the state designated as a Rural Medical Service Study Area (MSSA). A rural MSSA is an area with (1) a population density of less than 250 persons per square mile, and (2) no incorporated community with a population greater than 50,000 within the area. Further information about rural MSSAs can be accessed via the internet at www.ruralhealth.ca.gov or by calling Alba Quiroz-Garcia, Program Analyst, at (916) 327-7969.

- **Special Populations Strategy:** The Special Populations Strategy funds projects in communities with underserved populations of migrant or seasonal farm workers (such as farm workers and fishing and forestry workers) and American Indians. Plans submitting proposals under the Special Populations Strategy must address barriers preventing access to health care for these special population groups. Under this strategy, MRMIB provides lump sum payments to HFP participating plans to expand services to one or more of the designated special populations.

  The definition of special populations is provided in the HFP regulations (Title 10, CCR Section 2699.6500 (kk)). The RHDP for special populations is not limited to rural areas of the State, and can be for any area where there is a need to address unique access problems of the special populations.

MRMIB has funded 278 projects through the HFP RHDPs since 1998. Examples of projects funded include: (1) extended provider hours, (2) mobile dental and health vans, (3) increased available providers by funding medical personnel, (4) rate enhancements to develop or increase services in areas where health care services are not available, and (5) telemedicine.

The State is requesting creative solutions or ideas under either the Geographic Access or Special Populations strategies, or both. Examples of projects that could be funded include:

- Increased hours of clinic operations (evenings and weekends)
- Increased number of providers available to subscribers at remote facilities (family practitioners, pediatricians, nurses, dentists, pedodontists, dental hygienists, dental assistants, ophthalmologists, optometrists)
- Mental health and/or substance abuse services
- Health education in the areas of diabetes and obesity, including nutrition counseling programs

- Community-based preventive care and health promotion programs
- Mobile health vans
- Mobile dental vans covering rural areas in multiple counties
- Transportation services
- Telemedicine
- Use of "Promotores de Salud" (promoters of health) to provide public health education in areas such as high blood pressure control, prevention and reduction of cancer, asthma, childhood lead poisoning and other public health issues prevalent in the state.

MRMIB encourages plans, in developing proposals for MRMIB's consideration, to work collaboratively with providers who have historically provided health care services to the special populations or services to subscribers in rural geographic areas. The knowledge and experience of those providers may help plans identify the most effective strategies to address the unique access problems of special populations or subscribers residing in rural geographic areas.

All health, dental and vision plans proposing RHDP projects should be familiar with Title XXI of the federal Social Security Act, the authorizing state statutes (Insurance Code Section 12693 et seq.), and the program regulations (California Code of Regulations, Title 10, Chapter 5.8).

In order to be selected for participation in RHDP, a plan must be awarded a contract by MRMIB to participate as a health, dental, or vision plan in the Healthy Families Program for 2005-08. MRMIB will announce HFP contract awards at its March 2, 2005 meeting. All plans selected for participation in the RHDPs will be expected to have their projects and any collateral materials approved by their regulatory entities (if necessary) and ready for implementation no later than July 1, 2005. Potential contractors should time their regulatory filing to coincide with these dates. Entities unable to meet these timelines will not be eligible to participate.

Funding for Special Populations

The MRMIB will make available $1.4 million in funding for Fiscal Year (FY) 2005-06 to increase access for HFP members in special populations. Funding for FY 2006-2007 is subject to future appropriations by the legislature. Funding will be provided by MRMIB through a lump sum payment for specified services and/or deliverables.

Funding for Geographic Access

The MRMIB will also make available $1.4 million in funding for fiscal year 2005-06 to increase access to HFP subscribers in isolated rural areas. Funding for FY 2006-2007 is subject to future appropriations by the legislature. Funding will be provided by MRMIB to participating plans on either a per enrolled child per month basis for those subscribers enrolled in the identified isolated rural areas (rural MSSAs) or through a lump sum payment for specified services and/or deliverables.

Contracting Process

The necessary contractual provisions will be prepared as an exhibit to a health, dental, or vision plan's HFP contract.

The HFP enabling legislation exempts the MRMIB from the provisions of state law related to competitive bidding. The MRMIB will use a competitive negotiation process to select plans to participate in the MRMIB administered aspects of the RHDPs.

This solicitation is being made available to all health, dental and vision plans submitting proposals under the general HFP solicitation (see Enclosure 1), whether or not they are current contractors. Plans must identify: (a) the geographic region for which they are submitting a RHDP proposal (it may cover more than one area and may cover urban MSSA's for special populations), (b) the strategy the plan is attempting to address, (c) the ideas and creative solutions the plan proposes, and (d) the network of providers and services available in the plan and the cost**.** A plan may submit an RHDP proposal for both strategies. The Rural Health website, www.ruralhealth.ca.gov, provides an overview of rural areas of California to assist plans in identifying the rural MSSAs where proposed services will be provided.

After the release of this solicitation and prior to the final date for submission of proposals, all interested health, dental, or vision plans should arrange to meet with staff from the MRMIB to discuss the RHDP, the contractual requirements, and the plan's network and capabilities for providing access under the Special Populations or Geographic Access strategies. In addition, plans should be prepared to discuss their ideas for submission of proposals with MRMIB staff. Plans interested in participating in the RHDPs should contact Mauricio Leiva, Operations Manager, at (916) 445-2107 or Alba Quiroz-Garcia, Program Analyst, at (916) 327-7969 to discuss their interests and schedule a meeting to begin the negotiation process.

Selection of Projects for Special Populations Access

All proposals will be reviewed in their entirety using the following criteria:

1. All wording changes requested by a plan in the language of the Administrative Provisions, including (a) those that indicate a plan's inability or unwillingness to meet stated requirements or to accept other contractual terms and/or language; and (b) proposed improvements to the terms of the Administrative Provisions.

2. Relative effectiveness of the proposal in addressing the unique access needs of one or more identified special populations and the extent to which the proposal is designed to reduce health disparities among children in the target population.

3. The plan's ability to improve access for the special population(s). Factors that will be considered include, but are not be limited to, the plan's proposed network of providers, clinics and other facilities available to the special populations, the inclusion of providers who have experience serving the special population, and the ability to overcome obstacles related to geographic boundaries.

4. Ability to implement the proposed project on time. For example, if funding for health care providers is requested, plan partners must demonstrate their ability to fill the requested positions on a timely basis. If the request includes the use of a mobile health or dental van, the plan must indicate whether all appropriate licenses have been secured and if the vehicle is ready to be placed in service. Plans must address all other issues pertinent to the delivery of services in accordance with specified project goals, objectives and timelines.

5. The cost effectiveness of the plan's proposal, as demonstrated by the plan's cost to deliver specified benefits to special populations (price) relative to the services offered.

6. The plan's ability to collect and report demographic and utilization data for all children assisted through the RHDP on a quarterly basis.

Selection of Projects for Geographic Access

All proposals will be reviewed in their entirety using the following criteria:

1. All wording changes requested by a plan in the language of the Administrative Provisions, including (a) those that indicate a plan's inability or unwillingness to meet stated requirements or to accept other contractual terms and/or language; and (b) proposed improvements to the terms of the Administrative Provisions.

2. Relative effectiveness of the proposal to improve or increase the accessibility of services to subscribers in rural areas as well as the ability to provide services to eligible children in the rural area (rural area is defined as one or more rural MSSAs).

3. An area's need for additional services as identified by the unique access barriers, the potential number of eligible children, and the current HFP network (including traditional and safety net providers as defined by MRMIB in the program regulations) available to subscribers in a given rural area.

4. The plan's proposed network of providers, clinics and other facilities, the inclusion of traditional and safety net providers, as defined by MRMIB in the program

regulations, the network available to the subscribers, and/or the hours services will be available for subscribers in the designated rural area. (This will include analyzing what services and/or providers are being offered in the RHDP in addition to the plan's current HFP network available to subscribers in that rural area.)

5. Ability to implement the proposed project on time. For example, if funding for health care providers is requested, plan partners must demonstrate their ability to fill the requested positions on a timely basis. If the request includes the use of a mobile health or dental van, the plan must indicate if all appropriate licenses have been secured and if the vehicle is ready to be placed in service. Plans must address all other issues pertinent to the delivery of services in accordance with specified project goals, objectives and timelines.

6. The cost effectiveness of the plan's proposal, as demonstrated by the plan's cost to deliver specified benefits to subscribers through either an enhanced rate or a lump sum payment and limitations on administrative costs (price) in order to focus the enhanced premium rates or lump sum payments for benefit costs, relative to the services offered.

7. The plan's ability to collect and report demographic and utilization data for all children assisted through the RHDP on a quarterly basis.

Evaluation of Proposals

Individual factors will not be given a specific number of points in the evaluation process. Proposals will be evaluated in their entirety. The evaluations will be comparative. During the review process, the State may enter into negotiations with potential plans on the contents of the proposal submission, including the price of the proposal and the potential for reducing the requested amount. The State reserves the right to accept a proposal as submitted.

The MRMIB will select projects based on its assessment of the best overall value to the State. The MRMIB is scheduled to select plans to participate in the RHDP at the March 23, 2005 board meeting.

Proposal Format

A complete proposal includes all of the items listed below.

Four complete copies of all of the requested items, filed in separate three-ring binders, must be received by MRMIB at 1000 G Street, Room 450, Sacramento, CA 95814 by **5:00 p.m. on January 14, 2005**.

Items to be submitted:

1. Cover Letter

This letter should be on the plan's letterhead and signed by a person able to enter into contracts on behalf of the plan. The letter should include the name, title, phone, and fax number of the plan's contact person for any follow-up contact required by the MRMIB. The letter should also include an outline of the number of proposals submitted in the Special Populations and Geographic Access strategies and the total dollar amount requested for each strategy.

2. Contract Exhibit Administrative Provisions
Enclosed is the 2005-2007 Rural Health Demonstration Project Contract Exhibit Administrative Provisions. Entities interested in contracting with the MRMIB should review the exhibit language. Several areas of the Contract Exhibit require plans to provide "fill in the blank" information. All such areas should be completed prior to submission.

3. Additional Requested Items

   a. **For the Special Populations Access RHDP -** a listing, including the name, address, city, county, zip code, and provider specialty of the proposed providers, clinics and other facilities in the plan's network available to the special population. Indicate if the provider, clinic or other facility is currently part of the health plan HFP network or is an addition to the current network. Additionally, include a description of the number of individuals the provider, clinic and other facility currently serves from each special population, and a description of services and or programs currently provided by the provider, clinic and other facility for the special population. Mark in bold the providers, clinics and other facilities that have experience providing services to the special populations. Plans are encouraged to include letters of support from the providers, clinics and other facilities that are included in their network of the special population RHDP submission. **(See Attachment V.)**

   b. **For the Geographic Access RHDP -** a listing, including the name, address, city, county and zip code and specialty of service of the proposed providers, clinics and other facilities in the plan's network available to the subscribers in the rural area and if applicable, the hours of services that will be made available to subscribers in specified rural areas. Indicate if the provider, clinic or other facility is currently part of the health plan HFP network or is an addition to the network. Mark in bold the providers, clinics and other facilities that are designated by the program regulations as traditional and safety net providers. Place an asterisk next to the providers, clinics and other facilities that are located in the rural MSSA proposed for the RHDP.) Plans are encouraged to include letters of support from the providers, clinics and other facilities in

their network for the geographic access RHDP submission. (**See Attachment V.)**

c. A description of the plan's administrative costs for each project (both in total dollars as well as in percentages of the total project request). Administrative costs can not exceed 10% of the total spending of a RHDP project. Administrative costs are considered in the selection process of each RHDP project under the cost effectiveness criteria. Please attach the description of the administrative costs to Attachment II.

d. A completed Confidential Attachment Rates of Payment or Lump Sum Payment. Please complete only the rate section for the rural regions that your proposal will serve. **(See Attachments III and IV.)**

e. Completed proposals in the **Proposal Format** document provided in **Attachment II.** Proposals must include a detailed project description, break out of the use of the rate enhancement funds or lump sum funding requested, and all other information requested in the proposal format document.

Attachments:

Attachment I: Administrative Provisions
Attachment II: Proposal Format
Attachment III: Confidential Attachment Rates of Payment 2005-06
Attachment IV: Confidential Attachment Rates of Payment 2006-07
Attachment V: Projects Listing

RURAL HEALTH DEMONSTRATION PROJECT ADMINISTRATIVE PROVISIONS

[Note: For bidders chosen to conduct Rural Health Demonstration Projects, Attachments I through V will become an additional Exhibit F to the HFP Contract.]

I. The purpose of this Attachment is to add provisions for the implementation; monitoring and payment for the Healthy Families Program Rural Health Demonstration Project (s) awarded to the Contractor for the contract period of July 1, 2005 though June 30, 2007.

II. The contractor agrees to provide services to children eligible for the program through projects listed in Attachment V, Rural Health Demonstration Projects Listing:

III. Geographic Areas Covered

A. In addition to the counties listed in the geographic area grid, the Contractor is also participating in the special population component of the Rural Health Demonstration Project to increase and improve the accessibility of services to special populations, as defined in the program regulations, CCR, Title 10, Chapter 5.8, Article1, through projects listed in Attachment V.

B. The Contractor is also participating in the geographic access component of the Rural Health Demonstration Project to increase and improve the accessibility of services to residents of Rural Medical Services Study Areas, as defined in the program regulations, CCR, Title 10, Chapter 5.8, Article 1, through projects listed in Attachment V.

IV. Rural Demonstration Project

The Contractor shall participate in the Rural Demonstration Project for special populations and/or for improved access to rural subscribers in the program. The Contractor agrees to provide the services listed in Attachment V and as specified in each project proposal approved for funding. The Contractor shall provide these services through the network of projects listed in Attachment V. The Contractor shall inform the State of all its monitoring activities ensuring the provision of services related to the Rural Health Demonstration Projects. The Contractor understands that the State may perform on-site inspections to monitor the Contractor's compliance with the Rural Health Demonstration Project contract terms.

V Rural Demonstration Project Progress Reports

A. The Contractor shall submit to the State a progress report on each Rural Health Demonstration Project listed in Attachment V on forms provided by the State. The progress reports shall contain information on the progress that each project has made in accomplishing the project's goals for the preceding quarter. The reports must include, but are not limited to, the following information:

1. A comparison of actual accomplishments to the objectives established for each project for the quarter;

2. If established objectives are not being met, a statement of the reasons explaining the delay;

3. Any additional pertinent information, including but not limited to analysis and explanation of any delays or problems in project implementation.

B. The contractor shall submit reports according to the following schedule:

1. Reports for the quarter ending September 30, 2005 will be due on November 15, 2005

2. Reports for the quarter ending December 30, 2005 will be on February 15, 2006

3. Reports for the quarter ending March 30, 2006 will be due on May 15, 2006

4. Reports for the quarter ending June 30, 2006 will be due on August 15, 2006

5. Reports for the quarter ending September 30, 2006 will be due on November 15, 2006

6. Reports for the quarter ending December 30, 2006 will be due on February 15, 2007

7. Reports for the quarter ending March 30, 2007 will be due on May 15, 2007

8. Reports for the quarter ending June 30, 2007 will be due on August 15, 2007

VI. Rural Health Demonstration Project Payment Provisions

A. The State agrees to pay a total of $XXXXXX to the Contractor for the project period of July 1, 2005 through June 30, 2006, as follows:

1. $XXXXXX for projects related to geographic access as described in Attachment V.

2. $XXXXXX for projects related to special population members as described in Attachment V.

3. In addition, the State shall pay the enhancement to the per-child rate, specified by region, described in the Confidential Attachment Rates of Payment - Rural Health Demonstration Projects 2005-06 (Attachment III). **[Note: This provision is applicable only to plans that have projects approved for rate enhancements]**

4. The Contractor shall submit monthly statements in arrears for services rendered until the total lump sum has been expended. The invoice shall be submitted in a format provided by the State and shall include a brief description of the services provided.

5. Any funds related to the Rural Health Demonstration Project that remain unspent by June 30, 2006 may be carried forward into the next State Fiscal Year, contingent upon satisfactory progress by the Contractor and continuation of this Agreement for the duration of the next State Fiscal Year.

B. The State agrees to pay a total of $XXXXXX, contingent on RHDP funding by the legislature, to the Contractor for the project period of July 1, 2006 through June 30, 2007, as follows:

1. $XXXXXX for projects related to geographic access as described in Attachment V.

2. $XXXXXX for projects related to special population members as described in Attachment V.

3. In addition, the State shall pay the enhancement to the per-child rate, specified by region, described in the Confidential Attachment Rates of Payment - Rural Health Demonstration Projects 2006-07 (Attachment IV). **[Note: This provision is applicable only to plans that have projects approved for rate enhancements.]**

4. The Contractor shall submit monthly statements in arrears for services rendered until the total lump sum has been expended. The invoice shall be submitted in a format provided by the State and shall include a brief description of the services provided.

C. The Contractor agrees that the provisions of the specific projects of the Rural Health Demonstration Project, as described in Attachment V, must be fully and satisfactorily met in order to retain funding. The Contractor agrees that if the State determines that any provision or specific project has not been fully met, or has not been fully performed to the State's satisfaction, the State may initiate one or more of the following actions:

1. Temporarily withhold payments pending correction of the identified deficiency by the Contractor or disallow activities not in compliance.

2. Suspend or cancel all or part of the specific Rural Health Demonstration Project in question.

3. Demand repayment from the Contractor for any payments paid to Contractor for the specific Rural Health Demonstration Project in question. The Contractor may request that the State establish a repayment plan for the funds demanded by the State. The State reserves the right to approve or deny the Contractor's request for establishment of a repayment plan for such funds. The State also reserves the right to offset the funds demanded against other State funds owed to the Contractor under the Rural Health Demonstration Projects.

2005-2007 RURAL HEALTH DEMONSTRATION PROJECT-PROPOSAL FORMAT

Participating Plan Name: _____ **Project Number:** _____

Project Title: _____

Check Project Type: ☐ **Special Population** ☐ **Geographic Access**

Special Population or Geographic Area to be served:

_____

Project Partner: _____
Is the partner currently part of the plan's HFP network? If not, when will they be added?

Location(s): Describe the geographic location of the project including county and city.
Areas to be covered: MSSAs or counties covered.

**Please note that projects for Geographic Access must be located in a rural Medical Services Study Area (MSSA). To verify MSSA information log onto www.ruralhealth.ca.gov or call Alba Quiroz-Garcia at (916) 327-7969.*

Special Population Project Description: Describe how the project will address the unique access needs of special populations and the extent to which the proposal is designed to reduce health disparities among children in the target populations.

Geographic Access Project Description:
Describe how the project will address the unique access needs of geographically isolated rural and frontier areas. The type of services needed in the community, the availability of providers or how the project will make providers available where services are non-existent.

Use additional space as necessary, but limit this section to no more than 2 pages, project description should be concise and clear.

BUDGET

Project Period Requested (check all that apply) ☐ 7/1/05 – 6/30/06 ☐ 7/1/06 – 6/30/07
For each period requested, please complete the following:

Project Budget 7/1/05 – 6/30/06

Is reimbursement requested for: (check one) ☐ Lump Sum ☐ Rate Enhancement

Itemized Total Budget Requested for:

Personnel Salaries $ _____

Fringe Benefits (%) _____ $ _____

Other direct program costs $ _____

Supplies and collateral materials $ _____

Total (less admin costs) $ _____

Plan Administration % ____ $ _____

Grand Total $ _____

Project Budget 7/1/06 – 6/30/07

Is reimbursement requested for: (check one) ☐ Lump Sum ☐ Rate Enhancement

Itemized Total Budget Requested for:

Personnel Salaries $ _____

Fringe Benefits (%) _____ $ _____

Other direct program costs $ _____

Supplies and collateral materials $ _____

Total (less admin costs) $ _____

Plan Administration % ____ $ _____

Grand Total $ _____

PROVIDER'S EXPERIENCE WITH THE SPECIAL POPULATION OR GEOGRAPHIC ACCESS AREAS

Special Population-Describe provider's experience with special population, including how long they have been serving the special population, the estimated numbers of special population served annually and the source for the reported numbers – OSHPD, Medi-Cal, self-reported or other.
Geographic Access-Describe providers experience working with geographically isolated communities and knowledge of community needs.

Estimated number of HFP children enrolled in plan in areas to be served:

Estimated number of HFP children to be served by project:

Expected outcomes: For example, reduction in health disparities in children in the special population or increasing access to health care in geographic isolated communities. Describe what the project will demonstrate.

Project Feasibility: Can the plan partner meet the established goals and objectives according to timelines? If staffing is requested, has any work been initiated to find the healthcare provider requested? Have any issues related to licenses or operating permits been addressed prior to submitting proposals, and are projected timelines realistic?

Data Collection and Reporting: Provider's ability to collect and report demographic and utilization data. Describe how the data collection process will be implemented. Provide some detail of your data processing capabilities.

Other: Include if the plan project partner has been funded through the RHDP in the past from MRMIB? If yes, list the year, project number and funding amount.

Any other information that justifies your request and strengthens your proposal.

** Proposals submitted must address all areas outlined in this format.*

Premium Rates for the Rural Health Demonstration Projects

Listed on Attachment V for contract year 2005-06

Rural Demonstration Project: Proposed Rate Enhancement - Geographic Access Proposals Only

Rates by Region	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per subscriber per month rate ages 1 thru 18						

Rates by Region	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per subscriber per month rate under age one*						

Plans are to leave infant rates blank. MRMIB will calculate infant rate.

Rural Demonstration Project: Lump Sum Payments-Geographic Access

Project	Project #	Project #	Project #	Project #	Project #	Project #
Requested Payment						

Project	Project #	Project #	Project #	Project #	Project #	Project #
Requested Payment						

Rural Demonstration Project: Lump Sum Payments for Special Populations

Project	Project #	Project #	Project #	Project #	Project #	Project #
Requested Payment						
Project	Project #	Project #	Project #	Project #	Project #	Project #
Requested Payment						
Project	Project #	Project #	Project #	Project #	Project #	Project #
Requested Payment						

Healthy Families Program
Rural Health Demonstration Project
Proposed Projects for Fiscal Year 2005-06 and 2006-07
Special Population

Project ID #	Plan Partner	Plan Partner's Address	County & City Service Area	Is Provider in Plan's Network	Traditional & Safety net Provider	Proposed # of children to be served	Budget Requested 2005-06	Budget Requested 2006-07	Plan's Admin Fee %	PROJECT DESCRIPTION

Healthy Families Program
Rural Health Demonstration Project
Proposed Projects for Fiscal Year 2005-06 and 2006-07
Geographical Access

Project ID #	Plan Partner	Plan Partner's Address	County & City Service Area	Is Provider in Plan's Network	Traditional & Safety net Provider	Proposed # of children to be served	Budget Requested 2005-06	Budget Requested 2006-07	Plan's Admin Fee %	PROJECT DESCRIPTION